Patient name: _____

► MEDICAL HISTORY

Do you currently have or have you ever had any problems in the following areas?

Condition	Patient History Yes	No	Details	Family History Yes	No	Details
GENERAL CONSTITUTIONAL (fever, weight loss / gain, etc.)						
CATARACTS						
GLAUCOMA						
MACULAR DEGENERATION						
EYES (loss of vision, double vision, retinal detach, etc.)						
EARS, NOSE, THROAT, MOUTH (earache, stuffy nose, cough, dry mouth, etc.)						
RESPIRATORY / ASTHMA (COPD, wheezing, congestion, etc.)						
CARDIOVASCULAR (heart attack, high blood pressure, etc.)						
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)						
KIDNEY, BLADDER, GENITAL (frequent urination, etc.)						
MUSCLES, BONES, JOINTS / ARTHRITIS (pain, stiffness, swelling, cramps, etc.)						
SKIN (cold sores, rash, Rosacea, etc.)						
NEUROLOGICAL / STROKE (numbness, headache, etc.)						
ENDOCRINE / DIABETES (thyroid condition, etc.)						
BLOOD / LYMPH (anemia, etc.)						
HEPATITIS / HIV						
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, itching, hives, redness, etc.)						
PSYCHIATRIC (anxiety, depression, insomnia, etc.)						
CANCER						
OTHER						
Do you have a pacemaker or defibrillator? □ NO □ YES						
Have you ever had an adverse reaction to anesthesia? □ NO □ YES If yes, explain:						

► SURGICAL HISTORY: including eye surgery & dates _____

► SOCIAL HISTORY:

Do you smoke or use tobacco? NO or YES If yes, how much per day? _____

Do you drink alcohol? NO or YES If yes, how much / often? _____

Female patients: Could you be pregnant now? NO or YES

Your last eye examination (if not here) Date: _____ By whom? _____

_____ _____

Patient signature Date

Office Use Only											
Initials											
Date											
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Initials											
Date											