

PATIENTS NAME: _____ DATE OF BIRTH: _____
MEDICAL HISTORY PRIMARY CARE DOCTOR _____

List the medications that you take regularly and the dosage: _____

Do you have allergies to any medications? List them: _____

List all operations that you have had and the year of the surgery: _____

Do you smoke (packs per day)? _____ Did you smoke in the past? _____
Do you drink (how many per day)? _____

Do you have high blood pressure? _____

Do you get chest pains (angina)? _____

Have you had a heart attack? (If so, when) _____

Have you had congestive heart failure? _____

Do you get palpitations? _____

Have you had rheumatic fever? _____

Do you have a heart murmur? _____

Do you have a pacemaker? _____

Do your legs (calves) get cramps when you walk a short distance? _____

Do you get shortness of breath if you do not sleep on 2 or more pillows? _____

Do you have asthma? _____

Do you have emphysema? _____

Have you been treated for TB? _____

Do you have stomach problems (ulcers)? _____

Have you ever been treated for anemia? _____

Do you have Sickle Cell anemia or trait? _____

Do you bruise or bleed easily? _____

PATIENTS NAME: _____

Have you ever had kidney failure? _____

Have you ever had kidney stones? _____

Do you have thyroid disease? _____

Do you have diabetes (how long)? _____

Do you have liver disease? _____

Have you had hepatitis? _____

Do you have arthritis? _____

Do you have epilepsy? (Seizures) _____

Have you ever had a stroke or mini stroke? _____

Do you have migraines? _____

Are you Pregnant or Nursing? _____

Do you have anxiety? _____ Do you have mood swings? _____

Do you have depression? _____ Do you have difficulty sleeping? _____

Have you fallen in the last year? ____ Did you get the pneumonia shot? ____

Do you have any other medical problems not listed? _____

History of eye problems:

Have you had eye surgery? _____ Do you have a lazy eye? _____

Have you had an eye injury? _____ Do you have an eye turn? _____

Do you have glaucoma? _____ Do you have floaters? _____

Do you have pain or irritation of the eyes? _____

Family history of eye problems:

Cataracts _____ Glaucoma _____ Diabetes _____

Macular degeneration _____ Lazy eye/eye turn _____

Blindness _____ Other _____

What are your present eye problems? Please explain _____

Patient's Signature X _____ Date: _____