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? _____

<u>PLEASE CONTINUE ON NEXT PAGE**</u>**

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? _____

<u>History of eye problems</u>:
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? _____

<u>Family history of eye problems:</u>
Cataracts_____Glaucoma_____Diabetes_____
Macular degeneration_____Lazy eye/eye turn _____
Blindness_____ Other_____

What are your present eye problems? Please explain _____
_____
_____

Patient's Signature X_____ Date: _____