MEDICAL HISTORY FORM

Patient Name: ____ **Age:** _______ **Sex:** ☐**M** ☐**F**

MEDICAL HISTORY:

Do you have?

DIABETES: ……………………….. **yes** ☐ no ☐

If yes, for how many years? ____________

Highest blood sugar within the past month? _______

Asthma: ……………………………...**yes** ☐ no ☐

Any breathing problem: ……………......**yes** ☐ no ☐

High blood pressure: ………………...**yes** ☐ no ☐

HIV: ………………………………..... **yes** ☐ no ☐

History of cancer: …………………... **yes** ☐ no ☐

Previous stroke: …………………….. **yes** ☐ no ☐

Do you have any other medical problem(s)?____________________________________ ☐ **NONE**

EYE HISTORY:

Do you have any **eye disease?**……… **yes** ☐ no ☐

If yes, please provide details:____

When was your **last eye exam**? __________ ago

Do you use **contact lenses:** ………..... **yes** ☐ no ☐

Do you wear **glasses**? ………………. **yes** ☐ no ☐ → ☐ check here if glasses are **only** for reading

Do you have a **lazy eye**? …………… **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐

Have you ever been **hit in your eye**?.. **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐

Have you had eye **surgery** before?..... **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐

If yes, please provide details and dates below:

____

Have you had **laser** eye surgery?........ **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐

If yes, please provide details and dates below:

____

EYE DROPS: (list all eye drops you use and how often you use them**)**……………..…… ☐ **NONE**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

MEDICATIONS (PILLS): (only write down the name, NOT the dose)………………... ☐ **NONE**

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

ALLERGIES:

Are you **allergic** to any medicine:…...**yes** ☐ no ☐

If yes, please provide name of the medicine(s):……… ☐

(PLEASE TURN TO SIDE 2 →)

MEDICAL HISTORY FORM (page 2)

FAMILY HISTORY:

Anyone in your family have **glaucoma**?……**yes** ☐ no ☐

If yes, who: ________________________________

Anyone in your family **blind**?……………... **yes** ☐ no ☐

Any **eye disease** that runs in your family?.....**yes** ☐ no ☐

If yes, please explain:_________________________

Is anyone in your family **cross-eyed**? ………**yes** ☐ no ☐

SOCIAL HISTORY:

Do you:

Smoke:……………………………………… **yes** ☐ no ☐ If yes how often…………..

Drink alcohol…………………………….. **yes** ☐ no ☐ If yes how often…………..

GENERAL MEDICAL QUESTIONS:

Do you have:

Fever:……………………………………… **yes** ☐ no ☐

Frequent Headaches: ……………………… **yes** ☐ no ☐

Sudden Loss of vision: …………………… **yes** ☐ no ☐

Are you pregnant: ……………………….... **yes** ☐ no ☐

Muscle weakness: ………………………… **yes** ☐ no ☐

Numbness: ……………………………….... **yes** ☐ no ☐

Rash: ……………………………………… **yes** ☐ no ☐

History of herpes near the eyes: ……………**yes** ☐ no ☐

Cough: ……………………………………...**yes** ☐ no ☐

Shortness of breath: ……………………...**yes** ☐ no ☐

Have you had a heart attack: ………………**yes** ☐ no ☐

History of Tuberculosis: ………………….... **yes** ☐ no ☐

If yes, were you treated? ……………**yes** ☐ no ☐

Stomach Pain: …………………………….... **yes** ☐ no ☐

Diarrhea: …………………………………... **yes** ☐ no ☐

Blood in your stool: ……………………….. **yes** ☐ no ☐

Recent weight loss: ……………………….... **yes** ☐ no ☐

Recent decreased appetite: …………………**yes** ☐ no ☐

Pain when you urinate: …………………… **yes** ☐ no ☐

Joint pain: ………………………………… **yes** ☐ no ☐

Muscle pain: ……………………………… **yes** ☐ no ☐

Low back pain: …………………………… **yes** ☐ no ☐

SIGNATURE:

DATE: ____________