

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):.....

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 much?.....

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: _____