MEDICAL INFORMATION

Please fill out BOTH sides

NAME _____ DATE _____

REFERRING PHYSICIAN _____ CITY _____

PRIMARY CARE PHYSICIAN_____ CITY _____

PAST MEDICAL HISTORY

Medical History (*Do you have any of the following conditions*):

_____ Arthritis
_____ Asthma
_____ Atrial Fibrillation
_____ Cancer (type): _____
_____ Coronary Artery Disease
_____ Diabetes
_____ Emphysema (COPD)
_____ Heart Disease
_____ Hepatitis
_____ High Cholesterol
_____ High Blood Pressure
_____ HIV
_____ Stroke
_____ Thyroid Disease (Low / High)
_____ Other (please list):

_____

_____

Past Surgical History (*please list*):

OCULAR HISTORY

Eye Conditions (*please list*):

Eye Surgeries (*please list*):

Family History (*note relation*):

Cataract _____ Diabetes _____

Glaucoma _____ Heart Disease _____

Macular Degeneration _____ High Blood Pressure _____

Retinal Detachment _____ Other: _____

Other Eye Disease: _____

Have you had:

Flu Vaccine (date): _____ Pneumonia Vaccine (date): _____

CURRENT MEDICATIONS

Please list ALL (including over-the-counter) or attach a list:

MEDICATION ALLERGIES

Please list ALL or attach a list:

MEDICAL INFORMATION PAGE 2

NAME _____ DATE _____

SOCIAL HISTORY

Drug Use _____

Alcohol Use: ☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Smoking Status: ☐ Never smoked ☐ Former smoker ☐ Occasional smoker ☐ Current every day smoker

Do you still drive in the daytime? ☐ Yes ☐ No Do you still drive at night? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No Do you feel safe at home? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If yes, how much? _____

_____

REVIEW OF SYSTEMS

Do you have any problems in the following areas? (*Please check all that apply*)

General Health	☐ Normal	☐ Fever	☐ Other _____
Eyes	☐ Normal	☐ Blurred Vision	☐ Other _____
Ears, Nose, Mouth, Throat	☐ Normal	☐ Hearing Loss	☐ Other _____
Cardiovascular	☐ Normal	☐ Chest Pain	☐ Other _____
Respiratory	☐ Normal	☐ Short of Breath	☐ Other _____
Gastrointestinal	☐ Normal	☐ Stomach Pain	☐ Other _____
Hematology	☐ Normal	☐ Free Bleeder	☐ Other _____
Musculoskeletal	☐ Normal	☐ Weakness	☐ Other _____
Skin Conditions	☐ Normal	☐ Tumors	☐ Other _____
Neurological	☐ Normal	☐ Numbness	☐ Other _____
Genitourinary	☐ Normal	☐ Pregnant	☐ Other _____

_____

Reviewed by: Date:

_____

Reviewed by: Date:

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Reviewed by: Date:

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Reviewed by: Date:

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Reviewed by: Date:

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Reviewed by: Date: