PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. Please fill out every item. It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer as part of your records.

Full Name _____ **Male**____**Female**____ **Date of Birth** _____

Pharmacy (including location) _____ **Primary Care Physician** _____

State in your own words why you are here today. _____

PAST / PRESENT OCULAR HISTORY		DATE DIAGNOSED
Glaucoma		
Cataracts		
ARMD		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Strabismus		
Amblyopia		
Diabetes		
Dry Eye		
Refractive		
Other		

FAMILY HISTORY / RELATIONSHIP	
Glaucoma	
Cataracts	
ARMD	
Eye Injury	
Retinal Disease	
Other Disease	
Blindness	
Strabismus	
Amblyopia	
Diabetes	
Cancer	
Heart Disease	
Hypertension	
High Cholesterol	
Kidney Disease	
Stroke	

SOCIAL HISTORY

❑ Tobacco
❑ Drugs
❑ Alcohol

HOBBIES

_____
_____
_____
_____

TOBACCO STATUS

❑Current every day smoker
❑Current some day smoker
❑Smoker
❑Former Smoker
❑Never Smoker

Have you had any problems with anesthesia?

❑ Yes ❑ No

(Current Medications) Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications) ❑ Yes ❑ No If yes, please list below INCLUDING DOSAGE

MEDICATION NAME	DOSAGE/MG	HOW OFTEN TAKEN

(Medication Allergies) ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑ Yes ❑ No If yes, please list below

MEDICATION NAME	REACTION

Have you had any Surgery or Procedures?

❑ Yes ❑ No If yes, please list below

TYPE OF SURGERY/PROCEDURE	DATE