MEDICAL HISTORY

Name_____ **Birthdate**_____

Referring Doctor_____ **Family Doctor**_____

Reason for today's consultation:_____

Social History

Do you smoke? ☐**NO** ☐**YES** _____Per Day

Do you drink alcohol? ☐**NO** ☐**YES** How often? Daily / weekly/ socially

Do you exercise? ☐**NO** ☐**YES** How often? Daily / weekly / occasionally

Your Occupation_____ Do you drive? ☐**NO** ☐**YES** Do you live alone? ☐**NO** ☐**YES**

Ocular History

Have you ever had any **injuries to your eyes or face**? ☐ **NO** ☐ **YES** **When?**_____

Type of injury and treatment:_____

Have you ever had any **eye or eyelid surgeries or procedures**? ☐ **NO** ☐**YES**

Type of surgery and dates:_____

Have you every had any **facial or sinus surgeries or procedures**? ☐ **NO** ☐**YES**

Type of surgery and dates:_____

Have you ever been diagnosed with any **eye disease or condition**? ☐ **NO** ☐**YES**

Please explain_____

_____

Date of last eye exam: _____Doctor's name_____

Age when you first got glasses:_____How old is your present pair of glasses?_____

Medications

Do you use **artificial tears**? ☐**NO** ☐**YES** What brand?_____How often?_____

Do you use **any other over-the-counter eye drops, eye ointments, or eye medications**? ☐**NO** ☐**YES**

For what **condition**?_____Name?_____How often?_____

Do you use any **prescription eye drops, eye ointments or eye medication**? ☐**NO** ☐**YES**

Please list:_____

_____

Are you currently on a **therapeutic aspirin regimen**? ☐**NO** ☐**YES**

Please list your **current medications** (including **prescription** medication, **over-the-counter** medications, **vitamins**, **supplements** and **herbal products**):

Name	**Strength**	**times/day**	**Name**	**Strength**	**times/day**

Medical History

Do you have, or have you had previously, any problems in the following areas? Please indicate the condition and give approximate time of onset.

	NO	YES	Condition and approximate time of onset.
High blood pressure	☐	☐	_____
Heart disease	☐	☐	_____
Heart attack	☐	☐	_____
Arrhythmia	☐	☐	_____
Pacemaker?	☐	☐	_____
Defibrillator?	☐	☐	_____
Valve replacement?	☐	☐	_____
Lung / breathing problems	☐	☐	_____
CPAP?	☐	☐	_____
Neurological conditions	☐	☐	_____
Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid disease	☐	☐	_____
Stomach or intestines	☐	☐	_____
Muscular / skeletal	☐	☐	_____
Joint replacement	☐	☐	_____
Rheumatoid disease	☐	☐	_____
Infectious diseases	☐	☐	_____
Ears, nose, mouth or throat	☐	☐	_____
Psychiatric illness	☐	☐	_____
Cancer (including skin)	☐	☐	_____
Migraine headaches	☐	☐	_____

Date of last physical:_____ **Date of last EKG:**_____

Surgical History (please list any procedures / surgeries and approximate dates):

_____

_____

Reactions to or complications from anesthesia: _____

_____

Allergies to medications and reactions:_____

Are you allergic to eggs? ☐**NO** ☐**YES**

I acknowledge that current and past health information is essential to my medical / surgical care. I confirm that the above information I have provided is true and accurate to the best of my knowledge. I also confirm that I have not withheld any health information.

_____

Patient signature **Date**

☐**Reviewed**_____ ☐**Reviewed**_____

Date **Date**