MEDICAL HISTORY FORM

NAME _____**AGE** _____ **DATE** _____

REFERRING DOCTOR OR PERSON _____

EYE HISTORY: Do You Wear Glasses _____ Contact Lenses _____ Date of Last Eye Exam _____

EYE PROBLEMS: Please Check any of the following problems that y

LIST ALL MEDICINES: INCLUDE DOSAGE (i.e. mg) & HOW MANY TIMES TAKEN DAILY.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List any non-ocular surgery and date:-_____

SOCIAL HISTORY: **Smoke** __ NO ___ YES (Cigarettes, Cigars, Pipe) _____# per day. List any drugs: _____
Alcohol __ NO ___YES (Beer, Wine, Liquor) ____ Social or Indicate Daily Consumption _____

REVIEW OF SYSTEMS: (Circle or list problems you have in any area) **CHECK HERE IF NONE: _____**

CONSTITUTIONAL & INTEGUMENTARY: Fever, Weight Loss, Rash, Skin Disease _____

HEAD/NECK: Sinus Problems, Post–Nasel Drip, Runny Nose, Dry Mouth, Hearing Loss _____

RESPIRATORY: Cough, Bronchitis, Shortness of Breath, Asthma, Emphysema, COPD _____

CARDIOVASCULAR: Chest Pain, Congestive heart Failure, Irregular Rhythm _____

GASTROINTESTINAL: Vomiting, Ulcers, Diarrhea, Bloody Stools _____

GENITOURINARY: Genital Ulcers, Discharge, Kidney Stones, Blood in Urine _____

ALLERGIC/IMMUNOLOGIC & BLOOD/LYMPHATIC: Seasonal allergies, Hay Fever, _____

Neurologic, Neurologic, Psychiatric & Musculoskeletal: Headache, Migranes, Paralysis, Joint aches _____