

Patient Medical History

Date: _____

Name: _____ Date of Birth: _____

Sex: Male Female Weight: _____ Height: _____ Race _____

Reason for Visit?: _____

HEALTH HISTORY - please check all that apply & write diagnosis date (approx.)

<u>Cardiovascular:</u>	<u>Neurologic:</u>	<u>GI and GU:</u>	<u>Ear/Nose/Throat</u>
Heart Disease _____	Seizures/Convulsions	Ulcers	Hearing Loss
Angina	Alzheimer's	Colitis / Diverticulitis	Wear Hearing Aids
High Blood Pressure	Parkinson's	Liver / Hepatitis	
Pacemaker/Defibrillator	ADHD / ADD	Kidney	<u>Hematologic:</u>
Angina	Narcolepsy	Bladder	Anemia
Heart Murmur	Stroke _____	Prostate	Bleed / Bruise Easily
Atrial Fibrillation			HIV
High Cholesterol	<u>Respiratory:</u>	<u>Oncology:</u>	Hepatitis B and/or C
Congestive HF	Lung Disease	Cancer	
	Chest		<u>Eye or Eyelid Surgery Dates:</u>
<u>Musculoskeletal:</u>	Asthma	<u>Eye:</u>	
Arthritis	Sleep Apnea	Cataracts	
Joint Replacement	COPD	Glaucoma	
		Diabetic Retinopathy	
<u>Endocrine:</u>	<u>Skin:</u>	Macular Degeneration	
Diabetes	Keloids/Scarring	Retinal Disorders	
Thyroid	Herpes Simplex	Corneal Problems	

Are you Diabetic? Yes No Are you Diet Controlled? Oral Medication Controlled Insulin Controlled

When were you first diagnosed? _____

Are you on blood thinners? Yes No _____

Do you take aspirin? Yes No _____

Have you ever had a cold sore? Yes No _____

Do you have any metal or implants in your body? Yes No – if Yes, detail: _____

Have you had an EKG in the past 6 months? Yes No – if Yes, where: _____

Do you smoke or use tobacco? Yes No – if Yes, how much per week? _____

If don't currently smoke and have quit, please detail when: _____

Do you have any allergies? Yes No – if Yes, detail: _____

Past Medical History: Please list any surgery, injuries, operations, or hospitalizations other than eyes: _____

Who is your Primary Care Doctor? _____

Patient Medication History

Patient's Name: _____

Who is your Primary Care Doctor? _____

Are you allergic to any medications? Yes No, if Yes please list below:

Are you allergic to IODINE? Yes No

Do you need Pre-op antibiotics? Yes No

Please list all medications that you are currently taking including eye drops and vitamins

MEDICATION	STRENGTH	HOW OFTEN

Patient Signature: _____