## PATIENT MEDICAL HISTORY RECORD

Primary Doctor Referred by:	Date of Birth:/			Patient Name:				
Please answer the following questions about your current medical status and history.    Yes			Age:	Sex:				
Patient Medical History:   Yes	erred by:			Primary Doctor Refe				
Yes			medical status and history.	ut your current	uestions abo			
Cancer	No	Yes		No	Yes	r attent iviedical History.		
Heart Disease			Tuberculosis			Diabetes		
Thyroid Disease			High Blood Pressure			Cancer		
Allergies			Epilepsy			Heart Disease		
Frequent Headaches			Kidney Disease			Thyroid Disease		
Migraines			Arthritis			Allergies		
Dizzy Spells			Heart Attack			Frequent Headaches		
Dizzy Spells			Hearing Loss			Migraines		
Difficulty Breathing			_			Dizzy Spells		
Yes No Yes   Glaucoma   Dryness   Cataracts   Discharge   Cataracts   Discharge   Cataracts   Discharge   Cataracts   Discharge   Cataracts						Difficulty Breathing		
Glaucoma						Patient Eye History:		
Cataracts	No	Yes		No	Yes			
Muscle Problems			Dryness			Glaucoma		
Retinal Problems			Discharge			Cataracts		
Surgery			Irritation			Muscle Problems		
Laser Surgery			Floaters			Retinal Problems		
Blurry Vision/Loss of Vision			Flashing Lights			Surgery		
Double vision			Pain			Laser Surgery		
Family Eye History:  Yes  No  Yes  Glaucoma  □  □  Cataracts  □  Other Problem  Eye Muscle Problems  □			Inflammation			Blurry Vision/Loss of Vision		
Yes No Yes  Glaucoma □ □ Eye Surgeries □  Cataracts □ □ Other Problem □  Eye Muscle Problems □			Other Problem			Double vision		
Glaucoma   Cataracts   Cutaracts   Cutarac						Family Eye History:		
Cataracts   Other Problem  Eye Muscle Problems	No	Yes	_ ~ .		Yes	~.		
Eye Muscle Problems $\square$		_						
			Other Problem					
Please list all vitamins and medications you are presently taking. (Example: Tylenol, Vitamins,						Eye Muscle Problems		
	etc.)	Vitamins, etc	taking. (Example: Tylenol, '	u are presently	dications yo	Please list all vitamins and me		
Please list all eye medications you are presently using. (Example: Drops, Scrubs, etc.)		)	ample: Drops, Scrubs, etc.)	ently using. (Ex	you are pres	Please list all eye medications		
					-	-		

Chronic fever, unexpected weight loss or gain, or fatigue  Ear/nose/throat problems (ex: hearing loss, sinus problems, sore throat)  Heart problems (ex: chest pain, irregular heart beat)  Respiratory Problems (ex: shortness of breath, wheezing, coughing)  Gastrointestinal Problems (ex: heartburn, abdominal pain, diarrhea, vomiting)  Urinary Problems (ex: pain or discomfort, blood in urine)  Skin Problems (ex: rashes, excessive dryness)  Musculoskeletal Problems (ex: muscle aches, joint pain, swollen joints)  Neurological Problems (ex: numbness, weakness, headaches, paralysis)  Psychiatric Problems (ex: depression, anxiety)  Family & Social History  Do any medical or eye disease run in your family?  (Diabetes, High Blood Pressure, Cancer, Glaucoma, Macular Degeneration)  If Yes, please explain:  Date of last eye exam: Where:  Comments/Other Information:	Yes	No
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Date of last eye exam: Where:	Yes □	No
Comments/Other Information:		
Doctor's Signature Date		

Please list ALL food and drug allergies: