

### History Sheet

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ PCP: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

History List:


**Medical History and System Review:**

Yes No

- Diabetes: Diagnosed: \_\_\_\_\_
- Hypertension/High Blood Pressure
- Heart Disease  
(heart attack, heart pain, stroke)
- Lung Disease  
(asthma, chronic bronchitis, emphysema)
- Gastro-Intestinal Problems  
(reflux, ulcer)
- Genito-urinary Problems
- Skin Problems  
(herpes, psoriasis)
- Musculo-skeletal Problems  
(arthritis, joint pain)
- Neurological Problems  
(migraines, MS, seizures)
- Endocrine Problems  
(thyroid)
- Hematological Problems  
(anemia, cholesterol)
- Constitutional  
(unusual weight loss/gain)
- Ear, Nose, Mouth , Throat  
(dry throat/mouth, allergies, sinus)
- Other Medical Concerns

**Personal Eye History:**

Yes No

- Eye Injury
- Eye Surgery
- Cataracts
- Glaucoma
- Macular Degeneration
- Refractive Surgery
- Other

**Family History:**

Yes No

- Glaucoma                    M P S MGP PGP
- Macular Degen            M P S MGP PGP
- Other                        M P S MGP PGP

**Social History:**

Retired: Y / N Occupation: \_\_\_\_\_  
 Smoke? \_\_\_\_packs/day / Quit \_\_\_\_ / Never smoked  
 Alcohol: Rarely / Occasionally / Frequently/ None

**Medications:**

Eye Meds:

**Allergies and Reactions:**

Doctor Signature: \_\_\_\_\_

Date: \_\_\_\_\_