PATIENT MEDICAL HISTORY FORM

Today's Date: _____

Patient Name _____

Please CIRCLE all of the following that YOU have or currently experience:

Eyes

Blurred Vision
Double Vision
Flashes of Light
Floaters
Distorted Vision
Eye Pain
Eye Swelling
Redness or Discharge
Light Sensitivity
Tired Eyes
Cataracts
Glaucoma
Macular Degeneration
Dry Eyes

Allergies/Immune

Allergies
Drug Allergies(list below)

Cardiovascular

Heart Disease
High Blood Pressure
Vascular Disease

Endocrine

Diabetes
Thyroid Disease
Hepatitis

Neurological

Migraines
Headaches
Seizures
Multiple Sclerosis

Musculoskeletal

Arthritis
Joint Pain

Integumentary

Skin Problems
Breast Cancer

Respiratory

Asthma
Shortness-of Breath
Emphysema

Hematological/Lymphatic

HIV
Swollen Lymph Nodes

Ear/Nose/Throat

Sinus Problems
Dry Mouth
Chronic Ear Infections
Sjogren's Disease

Gastrointestinal

Acid Reflux
ED

Psychiatric

Nervous Disorder
Depression

Constitution

Fever
Weight Loss/Gain

Height: _____ Weight: _____

Do you use any of the following? Tobacco, Alcohol, Recreational Drugs. Amount:_____

Please list current medication you are taking:

_____ FOR _____
_____ FOR _____
_____ FOR _____
_____ FOR _____

Does anyone in your family have the following?

Glaucoma	Y N	Blindness	Y N	Retinitis Pigmentosa	Y N
Macular Degeneration	Y N	Hypertension	Y N	Heart Failure	Y N
Diabetes	Y N	Lazy Eye	Y N		

List drug allergies and past major illnesses, operations, and/or injuries including dates: