Name: ____ Sex: ☐ M ☐ F
Date of Birth: ____________________Height:_____________Weight:____________________

PATIENT MEDICAL HISTORY FORM

1) **Are you currently taking any medications?** ☐YES ☐NO If yes, **please list** them below (including aspirin, vitamins/supplements):____
____

2) **Allergies:** Do you have any **drug or food** allergies (**including** shellfish, iodine, latex, adhesive)?
☐YES ☐NO If Yes, please list: ____

3) Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or lazy eye, retinal detachment, macular degeneration, diabetes, cornea) ☐YES ☐NO If yes, please explain:
____

4) Have you had any surgery/hospitalization in the last five years? ☐ YES ☐ NO If yes, please provide date and reason:____

REVIEW OF SYSTEMS: Please check all conditions that you have:		PLEASE PROVIDE EXPLANATION
High cholesterol	☐	_________________________
High blood pressure	☐	_________________________
Cardiovascular (e.g. heart disease, chest pain, irregular heart beat)	☐	_________________________
Diabetes...	☐	_________________________
Thyroid	☐	_________________________
Chronic fever, unexpected weight loss/gain, fatigue	☐	_________________________
Ear/nose/throat(e.g. hearing loss, sinus problems, chronic cough)	☐	_________________________
Respiratory (e.g. asthma, emphysema)	☐	_________________________
Gastrointestinal (e.g.heartburn, ulcer, abdominal pain, diarrhea, vomiting)....	☐	_________________________
Urinary (e.g. kidney/bladder conditions, pain or discomfort, blood in urine)....	☐	_________________________
Skin (e.g. rashes, excessive dryness, rosacea, skin cancer)	☐	_________________________
Musculoskeletal (e.g. arthritis, muscle aches, joint pain, swollen joints)	☐	_________________________
Neurologic (e.g. stroke, numbness, weakness, headaches, paralysis)	☐	_________________________
Psychiatric (e.g. depression, anxiety)	☐	_________________________
Autoimmune deficiency (e.g. lupus, rheumatoid arthritis, HIV, hepatitis) ...	☐	_________________________
Cancer	☐	_________________________

SOCIAL HISTORY

Do you drink alcohol? ☐Yes ☐No **If yes:** ☐ Occasional ☐ 1 daily ☐ 2-3 per week ☐ 4+ per week
Do you smoke? ☐Yes ☐No **If yes:** ☐ Occasional ☐ 1/2 pack/day ☐ 1 pack/day ☐ 1+ pack/day

Any additional comments or family history you would like us to know:
____

____