ASSOCIATE OPHTHALMOLOGISTS

Patient Medical History Form

Name: _____ Date of Birth: _____ Date: _____
Occupation: _____

Medical Information

Primary Care Physician: _____ Referring Doctor: _____
TEL: _____ TEL: _____

Are you currently pregnant or breastfeeding?_____

List all **ILLNESSES** (Glaucoma, Diabetes, Heart attack, etc.) or **INJURIES** (Concussion, etc.):

_____

_____

List any **MEDICATIONS** you are currently taking (Prescription and over-the-counter (OTC):

_____

_____

Do you have any **ALLERGIES** to medications, substance or other allergens? _____
If YES, list the medications and substance: _____

List any **SURGERIES** you have had (cataract, glaucoma procedures, tonsillectomy, appendectomy, etc.):

_____

_____

Have you ever had **LASIK** surgery? _____ If YES, When & Where? _____

Family History

	YES	NO	Who? (GP,F,M,B,S,etc.)
Blindness	Y	N	
Glaucoma	Y	N	
Macular Degeneration	Y	N	
Cataract	Y	N	
Arthritis	Y	N	
Cancer	Y	N	
Diabetes	Y	N	
High blood pressure	Y	N	
Heart disease	Y	N	
Kidney disease	Y	N	
Lupus	Y	N	
Stroke	Y	N	
Thyroid Disease	Y	N	
Other	Y	N	

Do you **CURRENTLY** have any problems in the following areas?

Loss of vision	Y | N	Glare/light sensitivity	Y | N
Blurred vision	Y | N	Eye pain or soreness	Y | N
Fluctuating vision	Y | N	Infection of eye or lid	Y | N
Distorted vision (halos)	Y | N	Tired eyes	Y | N
Loss of side vision	Y | N	Crossed eyes, lazy eye	Y | N
Double vision	Y | N	Drooping eyelid	Y | N
Dryness	Y | N	Difficulty when driving	Y | N
Mucous discharge	Y | N	Night vision issues	Y | N
Redness	Y | N	Other eye issues	Y | N
Sandy or gritty feeling	Y | N	Fever	Y | N
Itching	Y | N	Weight Loss	Y | N
Burning	Y | N	Heart/Breathing issues	Y | N
Foreign body sensation	Y | N	Stomach/Kidney issues	Y | N
Tearing/watering	Y | N	Bone/Joint/Immune	Y | N

Contact Lens Information

Wear Glasses?_____

	Right Eye		Left Eye	
Brand				
Rx				
	B.C.	DIA	B.C.	DIA

Pharmacy Information

Name _____ Phone # _____ Fax # _____
Address _____

Social History

Smoking: Current, for _____ years / Quit, when?_____/ Never / Decline How much/often? _____
Alcohol: YES / NO How much/often? _____(ie. On occasion, Socially, 1 glass of wine/day, 2-3 beers/day, etc.)
Drugs: YES / NO Type:_____How much/often? _____
Others: _____

Signature: _____ Date: _____