Medical History Information Sheet:

Name: ________________________ D.O.B: __/__/__ Today's Date: __/__/__
Reason For Today's Visit: ____

Medical History: Please check any illness/condition YOU have.

__Allergies __Anemia __Arthritis __Asthma __Cancer __Depression

__Diabetes __Headache __Heart Issues__Hepatitis __High Blood Pressure

__High Cholesterol __Mental Illness __Seizures __ Stroke __Thyroid Disease

Please list any other conditions you have:____

Eye History: Please check any illness/condition YOU currently have.

__Blindness __Blurred Vision __Burning __Cataracts __Discharge

__Double Vision __Dryness __Flashes of Light __Floaters __Glare/Halos

__Itching __Light Sensitivity __Poor Night Vision __Red Eyes __Watering

Please list any other eye conditions you have:____

Eye Surgery History: Please list any prior Eye Surgeries you have had.

____

Family Eye History: Please check if your immediate family has ever had.

__Blindness __Cataracts __Diabetes __Glaucoma __Macular Degeneration

Social History: Please Check All That Applies.

Tobacco Use: __Never __Former __Current List Type:______________________
Alcohol Use: __Never __Frequent __Social List Type:______________________
Drug Use: __Never __Former _Current List Type:______________________

Allergic To Latex: __Yes __No Allery to Meds: __Yes __NO

Please List Drug Allergies: ____

Current Medications: Please List ALL Current Medications You Are Taking:

____

____

____