Medical / Eye History

Name _____Birth Date_____
Medical Dr._____Pharmacy_____

Do **YOU** have any of the following (if so please circle and explain)?

Genitourinary problems (bladder,kidney)_____
Ear/Nose/Throat problems_____
Gastrointestinal problems_____
Musculoskelatal disorders_____
Heart disease_____
Blood disorders (anemia)_____
Allergies_____
Breathing problems (asthma, COPD)_____
Neurological disorders (MS, Migraines)_____
Skin diseases (rosacea, eczema)_____
Psychiatric disorders (anxiety, depression)_____
Endocrine disorders (diabetes, thyroid)_____
Other_____

What, if any, medications are you allergic to? _____
Do you drive? _____
Do you use tobacco? _____
Do you use alcohol? _____
Do you use recreational drugs? _____
Have you ever had surgery(If so, explain)? _____
Have you ever been hospitalized (if so,explain)?_____
Have you ever had any eye surgery? _____
Are you pregnant? _____

Does anyone in your family (parents, grandparents, siblings,aunts,uncles)have any of the following (if so please circle and list who)?

Diabetes
High Blood Pressure
Heart Disease
Stroke
Lung disease
Thyroid disease
Cancer

Does anyone in your family (parents, grandparents, siblings,aunts,uncles) have any of the following eye diseases (if so please circle and list who)

Cataract
Glaucoma
Macular degeneration
Lazy eye
Dry eyes
Diabetic retinopathy
Blepharitis

Please list all medications including over-the-counter products, vitamins, and nutritional supplements.

_____
_____
_____
_____
_____

Physician initials_____Technician initials_____