Medical History Information

Patient name: _____ Date: _____

Primary Care Physician: _____

Are you allergic to any of the following (please circle):

Anesthesia	☐ Yes	☐ No
Cephalosporins	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Demerol	☐ Yes	☐ No
Iodine	☐ Yes	☐ No
Sulfa Drugs	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No

Please list any other allergies: _____

Please List all medications you are currently taking (including eye drops)

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Family Medical History:

(Please use abbreviation of family member relationship)

M = Mother **S** = Sister
F = Father **A** = Aunt
B = Brother **U** = Uncle
MG = Maternal Grandmother
PG = Paternal Grandmother
MGF = Maternal Grandfather
PGF = Paternal Grandfather

1) Cancer Who? _____
2) Cataracts Who? _____
3) Diabetes Who? _____
4) Glaucoma Who? _____
5) Heart Problems Who? _____
6) Macular Degeneration Who? _____
7) Retinal Detachment Who? _____

Social History:

Do you smoke? ☐ Yes ☐ No
If yes, Current or Ex smoker? (circle)
Do you drink alcohol? ☐ Yes ☐ No
Do you use illicit drugs? ☐ Yes ☐ No

Past History & Review of Systems

Have you had or still have the following medical conditions?

Allergic Symptoms	☐ Yes	☐ No	If yes, type _____
Blood Clotting Problems	☐ Yes	☐ No	
Bowel Problems	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	If yes, type _____
Cardiac Disease	☐ Yes	☐ No	
Chest Pain	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Eye Conditions	☐ Yes	☐ No	If yes, type _____
Hepatitis or Jaundice	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Migraine Headaches	☐ Yes	☐ No	
Immunologic Disorders	☐ Yes	☐ No	If yes, type _____
Neurological Disease	☐ Yes	☐ No	
Respiratory Problems	☐ Yes	☐ No	
Rheumatoid Arthritis	☐ Yes	☐ No	
Skin-related Problems	☐ Yes	☐ No	If yes, type _____
Stroke	☐ Yes	☐ No	If yes, when _____
Thyroid Problems	☐ Yes	☐ No	

Other: _____
_____

Have you ever had Lasik surgery?

☐ Yes ☐ No If yes, when? _____

Have you ever had a flu shot?

☐ Yes ☐ No If yes, how long ago? _____

Have you ever had a pneumonia vaccination?

☐ Yes ☐ No

Past Surgical History (including eye surgeries)

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____