

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) _____

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:	_____		

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

Cancer	Who? _____
Cataracts	Who? _____
Diabetes	Who? _____
Glaucoma	Who? _____
Heart Problems	Who? _____
Macular Degeneration	Who? _____
Retinal Detachment	Who? _____

Social History:

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

Have you ever had the following:

Lasik surgery Yes / No
Flu shot? Yes / No
Pneumonia vaccination? Yes / No
Covid vaccination? Yes / No
Tdap vaccination? Yes / No
Shingles vaccination? Yes / No

Past Surgical History: (including eye surgeries)

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