## Medical History It's important that we learn your history!



MEDICAL DOCTOR'S First & Last Name	PA1	TIENT NAME		DATE OF BIRTH				
Phone Number    Phone Number   Phone Number   Phone Number		ALEDIAN DOCTORIO TI I CONTROLO						
Allergies to Medications Y or N If yes, please list reaction:  Please list all major operations or hospital admissions including eye surgeries and lasers with approximate dates.  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  DATE  PROCEDURE  DATE  DATE  PROCEDURE  DATE  DATE  PROCEDURE  DATE  DATE  DATE  DATE  DATE  PROCEDURE  DATE	ACY	MEDICAL DOCTOR'S First & Last Name						
Allergies to Medications Y or N If yes, please list reaction:  Please list all major operations or hospital admissions including eye surgeries and lasers with approximate dates.  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  PROCEDURE  PROCEDURE  DATE  DATE  DATE  PROCEDURE  DATE  DATE  DATE  PROCEDURE  DATE  DA	RM/	Data Last Casa						
Allergies to Medications Y or N If yes, please list reaction:  Please list all major operations or hospital admissions including eye surgeries and lasers with approximate dates.  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  PROCEDURE  PROCEDURE  DATE  DATE  DATE  PROCEDURE  DATE  DATE  DATE  PROCEDURE  DATE  DA	HA							
Allergies to Medications Y or N If yes, please list reaction:  Please list all major operations or hospital admissions including eye surgeries and lasers with approximate dates.  PROCEDURE  DATE  DATE  DATE  DATE  PROCEDURE  DATE  DATE  DATE  DATE  PROCEDURE  DATE  D	1	PHARMACY NAME						
Allergies to Medications Y or N  If yes, please list reaction:  Please list all major operations or hospital admissions including eye surgeries and lasers with approximate dates.  PROCEDURE  DATE  DATE  DATE  DATE  DATE  PROCEDURE  DATE	РСР							
If yes, please list reaction:  Please list all major operations or hospital admissions including eye surgeries and lasers with approximate dates.  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  DATE  DATE  PROCEDURE  DATE  DATE  PROCEDURE  DATE  DATE  DATE  PROCEDURE  DATE				Fax Number				
Please list all major operations or hospital admissions including eye surgeries and lasers with approximate dates.  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  DATE  PROCEDURE  DATE  DATE  DATE  PROCEDURE  DATE  DAT		Allergies to Medications Y or N						
PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  PROCEDURE  DATE  DATE  PROCEDURE  DATE  DATE  DATE  PROCEDURE  DATE		If yes, please list reaction:						
Please list ALL MEDICATIONS including eye drops and herbal supplements. Name strength and dose. If you are using eye drops, write down how often you take the drops and which eye. If Medication list is attached, please check here.   MEDICATION  HOW OFTEN  Macular Degeneration Y N  Glaucoma Y N  Cataracts Y N  SOCIAL HISTORY (please circle)  DO YOU?  Drink alcohol? Y N  How often?  Have a history of drug abuse? Y N  Explain  Drive? Y N How often?		Please list all major operations or hospital	admissions including ey	e surgeries and lasers with approximate da	tes.			
Please list ALL MEDICATIONS including eye drops and herbal supplements. Name strength and dose. If you are using eye drops, write down how often you take the drops and which eye. If Medication list is attached, please check here.    MEDICATION		PROCEDURE	DATE	PROCEDURE	DATE			
Please list ALL MEDICATIONS including eye drops and herbal supplements. Name strength and dose. If you are using eye drops, write down how often you take the drops and which eye. If Medication list is attached, please check here.    MEDICATION								
Please list ALL MEDICATIONS including eye drops and herbal supplements. Name strength and dose. If you are using eye drops, write down how often you take the drops and which eye. If Medication list is attached, please check here.    MEDICATION	>							
Please list ALL MEDICATIONS including eye drops and herbal supplements. Name strength and dose. If you are using eye drops, write down how often you take the drops and which eye. If Medication list is attached, please check here.    MEDICATION	OR							
Please list ALL MEDICATIONS including eye drops and herbal supplements. Name strength and dose. If you are using eye drops, write down how often you take the drops and which eye. If Medication list is attached, please check here.    MEDICATION	IST							
FAMILY HISTORY (please circle & list relationship)  Blindness Y N Macular Degeneration Y N  Glaucoma Y N  Cataracts Y N  SOCIAL HISTORY (please circle) DO YOU?  Drink alcohol? Y N How often?  Smoke tobacco? Y N How often?  Have a history of drug abuse? Y N Explain  Drive? Y N How often?								
FAMILY HISTORY (please circle & list relationship)  Blindness Y N Macular Degeneration Y N  Glaucoma Y N  Cataracts Y N  SOCIAL HISTORY (please circle) DO YOU?  Drink alcohol? Y N How often?  Smoke tobacco? Y N How often?  Have a history of drug abuse? Y N Explain  Drive? Y N How often?	CA				re using eye drops, write			
FAMILY HISTORY (please circle & list relationship)  Blindness Y N Macular Degeneration Y N  Glaucoma Y N  Cataracts Y N  SOCIAL HISTORY (please circle) DO YOU?  Drink alcohol? Y N How often?  Smoke tobacco? Y N How often?  Have a history of drug abuse? Y N Explain  Drive? Y N How often?	EDI				LIOW OFTEN			
Blindness Y N Glaucoma Y N Cataracts Y N  SOCIAL HISTORY (please circle) Drink alcohol? Smoke tobacco? Have a history of drug abuse? Drive? Y N  Macular Degeneration Y N Other Hereditary Disease Y N  How often? How often? Explain Drive? How often?	Σ	MEDICATION	HOW OFTEN	MEDICATION	HOW OFTEN			
Blindness Y N Glaucoma Y N Cataracts Y N  SOCIAL HISTORY (please circle) Drink alcohol? Smoke tobacco? Have a history of drug abuse? Drive? Y N  Macular Degeneration Y N Other Hereditary Disease Y N  How often? How often? Explain Drive? How often?								
Blindness Y N Glaucoma Y N Cataracts Y N  SOCIAL HISTORY (please circle) Drink alcohol? Smoke tobacco? Have a history of drug abuse? Drive? Y N  Macular Degeneration Y N Other Hereditary Disease Y N  How often? How often? Explain Drive? How often?								
Blindness Y N Glaucoma Y N Cataracts Y N  SOCIAL HISTORY (please circle) Drink alcohol? Smoke tobacco? Have a history of drug abuse? Drive? Y N  Macular Degeneration Y N Other Hereditary Disease Y N  How often? How often? Explain Drive? How often?								
Blindness Y N Glaucoma Y N Cataracts Y N  SOCIAL HISTORY (please circle) Drink alcohol? Smoke tobacco? Have a history of drug abuse? Drive? Y N  Macular Degeneration Y N Other Hereditary Disease Y N  How often? How often? Explain Drive? How often?								
Blindness Y N Glaucoma Y N Cataracts Y N  SOCIAL HISTORY (please circle) Drink alcohol? Smoke tobacco? Have a history of drug abuse? Drive? Y N  Macular Degeneration Y N Other Hereditary Disease Y N  How often? How often? Explain Drive? How often?								
Blindness Y N Glaucoma Y N Cataracts Y N  SOCIAL HISTORY (please circle) Drink alcohol? Smoke tobacco? Have a history of drug abuse? Drive? Y N  Macular Degeneration Y N Other Hereditary Disease Y N  How often? How often? Explain Drive? How often?								
Cataracts Y N  SOCIAL HISTORY (please circle) DO YOU?  Drink alcohol? Y N How often?  Smoke tobacco? Y N How often?  Have a history of drug abuse? Y N Explain  Drive? Y N How often?								
Cataracts Y N  SOCIAL HISTORY (please circle) DO YOU?  Drink alcohol? Y N How often?  Smoke tobacco? Y N How often?  Have a history of drug abuse? Y N Explain  Drive? Y N How often?	۲۸	··	ionship)					
SOCIAL HISTORY (please circle)  Drink alcohol?  Smoke tobacco?  Have a history of drug abuse?  Y  N  Explain  Drive?  Y  N  How often?	MILY	Blindness Y N	ionship)					
Drink alcohol? Y N How often?  Smoke tobacco? Y N How often?  Have a history of drug abuse? Y N Explain  Drive? Y N How often?	FAMILY	Blindness Y N Glaucoma Y N	ionship)					
Smoke tobacco? Y N How often? Have a history of drug abuse? Y N Explain Drive? Y N How often?	FAMILY	Blindness Y N Glaucoma Y N	ionship)					
Have a history of drug abuse? Y N Explain Drive? Y N How often?	FAMILY	Blindness Y N Glaucoma Y N Cataracts Y N						
Drive? Y N How often?	FAMILY	Blindness Y N Glaucoma Y N Cataracts Y N SOCIAL HISTORY (please circle) D	O YOU?	Other Hereditary Disease Y N				
Drive? Y N How often?  Have visual difficulties driving? Y N Explain	FAMILY	Blindness Y N  Glaucoma Y N  Cataracts Y N  SOCIAL HISTORY (please circle) D  Drink alcohol? Y  Smoke tobacco? Y	O YOU? N N	Other Hereditary Disease Y N  How often?  How often?				
Have visual difficulties driving?  Y  N  Explain		Blindness Y N  Glaucoma Y N  Cataracts Y N  SOCIAL HISTORY (please circle) D  Drink alcohol? Y  Smoke tobacco? Y  Have a history of drug abuse? Y	O YOU? N N	Other Hereditary Disease Y N  How often?  Explain				
		Blindness Y N  Glaucoma Y N  Cataracts Y N  SOCIAL HISTORY (please circle) D  Drink alcohol? Y  Smoke tobacco? Y  Have a history of drug abuse? Y  Drive? Y	O YOU?  N  N  N	Other Hereditary Disease Y N  How often?  How often?  Explain  How often?				
		Blindness Y N  Glaucoma Y N  Cataracts Y N  SOCIAL HISTORY (please circle) D  Drink alcohol? Y  Smoke tobacco? Y  Have a history of drug abuse? Y  Drive? Y  Have visual difficulties driving? Y	O YOU?  N  N  N  N	Other Hereditary Disease Y N  How often? How often? Explain How often? Explain				
Wear glasses? Y N How old is present RX?  Wear contacts? Y N How old is present RX?		Blindness Y N  Glaucoma Y N  Cataracts Y N  SOCIAL HISTORY (please circle) D  Drink alcohol? Y  Smoke tobacco? Y  Have a history of drug abuse? Y  Drive? Y  Have visual difficulties driving? Y  Have problems with night vision? Y	O YOU?  N  N  N  N  N	Other Hereditary Disease Y N  How often? How often? Explain How often? Explain Explain				

EARS / NOSE / THROAT				<b>PSYCHIATRIC</b>			
Hay Fever / Other	Υ	N		ADHD	Υ	N	
Sinuses	Υ	N		Anxiety / Other	Υ	N	
				Autism	Υ	N	-
				Bipolar	Υ	N	
CARDIOVASCULAR				Claustrophobia	Υ	N	
Angina / Chest Pain	Υ	N		Depression	Υ	N	
Atrial Fibrillation (Afib)	Υ	N		Schizophrenia	Υ	N	-
Congestive Heart Failure	Υ	N					
Coronary Artery Disease	Υ	N					
Heart Attack	Υ	N		BLEEDING DISORDERS			
Heart Failure / Other	Y	N		Anemia	Υ	N	
Heart Murmur	Y	N		Blood Transfusion	Y	N	
Heart Valve Problems	Y	N		Coumadin Use	Y	N	
High Blood Pressure	Y	N		Easy Bruising	Y	N	
High Cholesterol	Y	N		Other Blood Thinner	Y	N	
nigh Cholesteroi	Y	IN		Other Blood Hilliner	r	IN	
RESPIRATORY / LUNG				IMMUNOLOGIC			
Asthma	Υ	N		AIDS	Y	N	
Emphysema	Υ	N		Fibromyalgia	Y	N	-
COPD				Hepatitis C			
COPD	Υ	N		<b>⊣</b> ∣ '	Y	N	
				HIV	Y	N	
				Lupus / Other	Y	N	
GASTROINTESTINAL				Rheumatoid Arthritis	Υ	N	
Reflux / Stomach Ulcer	Υ	N					
Colitis / Other	Υ	N					
Crohn's Disease	Υ	N		OTHER			
				Cancer	Υ	N	
				Arthritis	Υ	N	
ENDOCRINE				Gout	Υ	N	
Diabetes	Υ	Ν	□ Type I	Hearing Loss	Υ	N	
A1C			□ Type II	Hiatal Hernia	Υ	N	
Last Blood Sugar			□ Insulin	Melanoma	Υ	N	
	_		□ Non-Insulin	Osteoporosis	Υ	N	
Liver Disease	Υ	Ν					
Thyroid Disease	Υ	Ν	_				
				OTHER ILLNESSES NOT I	LISTED		
NEUROLOGIC							
Dementia	Υ	N					
Headache	Υ	N					
Memory Disorder	Υ	N					
Multiple Sclerosis	Υ	N		7			
Neuropathy	Y	N					
Parkinson's Disease	Y	N		-			
Seizures	Y	N					
JCIZUICJ	1	1.4		<b>⊣</b>			