Patient Medical History

Name: ____

Ocular History: Glaucoma Cataracts Macular Degeneration Lazy Eye Retinal Issues
Keratoconus Other: _______________________

Ear, Nose, and Throat: Hearing Loss Sinusitis Dry Mouth Other: _________________________________

Neurological: Multiple Sclerosis Epilepsy Cerebral Palsy Tumor Migraines Alzheimer's/Dementia
Other: ___________________________________

Psychological: Depression Anxiety Bipolar Other: ____________________________

Cardiovascular: Hypertension Stroke High Cholesterol Heart Disease Vascular Disease
Congestive Heart Failure Other: ______________________________

Respiratory: Asthma COPD Emphysema Sleep Apnea Other: ______________________________

Gastrointestinal: Crohn's Colitis Celiac Disease Ulcers Other: _____________________

Genitourinary: Kidney Disease Prostate Disease/ Cancer Herpes Chlamydia
Other: ________________________

Musculoskeletal: Arthritis Fibromyalgia Muscular Dystrophy Other: ____________________

Integumentary: Rosacea Melanoma Eczema Shingles Other: _______________________

Endocrine: Type 1 Diabetes Type 2 Diabetes Thyroid Dysfunction Hormonal Dysfunction

Primary Care Provider: ____ **Phone Number:** _________________________

Family History

Glaucoma: ____________________________
Cataracts: _____________________________
Macular Degeneration: _________________
Lazy Eye: ______________________________
Diabetes: ______________________________
Heart Disease: __________________________
Hypertension: ___________________________
Kidney Disease: _________________________
Other: ________________________________

Are you pregnant or nursing? ___Y ___N
Due Date: _____________
Do you drink alcohol? _____Y _____N
Do you smoke? _____Y _____N

Medications:
(Please list all current medications & dosage)

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Allergies____
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