MEDICAL HISTORY

Patient Name: ____ Date: ___________________

Medical History

Yes	No		Yes	No	
☐	☐	Hypertension # of years ____________	☐	☐	Pulmonary Disease
☐	☐	Liver	☐	☐	Kidney
☐	☐	Cardiac Disease / Chest Pain	☐	☐	Diabetes Last blood sugar ________ # of years _________
☐	☐	Cholesterol	☐	☐	Arthritis
☐	☐	Thyroid Disease	☐	☐	Infectious Diseases ☐ Hepatitis ☐ HIV ☐ TB ☐ MRSA
☐	☐	Stroke / TIA	☐	☐	Other: _________________________________
☐	☐	Latex Allergy			
☐	☐	Cancer type: ______________________			

Medications you are currently taking:

Medication	Dose	Frequency	Medication	Dose	Frequency	Medication	Dose	Frequency

Drug Allergies and Reactions: **HAVE YOU EVER TAKEN FLOMAX, AVODART OR JAYLN?** ☐ Yes ☐ No

________________________________ ______________________________ ______________________________

________________________________ ______________________________ ______________________________

Your Eye History: (Have you been diagnosed with any of the following conditions in the past?)

Yes	No		Yes	No	
☐	☐	Cataracts ______________________________	☐	☐	Eye Injury ____________________________________
☐	☐	Retinal Disease _________________________	☐	☐	Any Other Eye Disorders: _______________________
☐	☐	Glaucoma ______________________________			

☐ **Cataract Surgery date** Right ______ Left ________ ☐ **Retinal Surgery date** Right _______ Left ________

☐ **Yag Laser date** Right _______ Left ________ ☐ **LASIK Surgery date** Right _______ Left ________

Surgical History and Hospitalizations within the last year:

Type of surgery / reason for admission	Surgery/admission date	Type of surgery / reason for admission	Surgery/admission date

Family History **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)? ☐ Yes ☐ No ☐ Unknown

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? ______________________

Do you smoke? ☐ Yes ☐ No If yes, how much? ______________________ How many years? ______

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