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MEDICAL HISTORY WORK SHEET

Name____________________ DOB____/____/____ Date Completed____/____/____

FAMILY HISTORY

Do any of the following run in your blood relatives? (Please circle if yes)

Glaucoma | Cataracts | Diabetes | Cancer
Lazy Eye | Blindness | Heart Disease | Other: __________
Macular Degeneration

PATIENT MEDICAL /SURGICAL HISTORY

Please list any medical conditions and major surgeries

1. __________
2. __________
3. __________
4. __________

PATIENT EYE HISTORY

Please list any eye surgeries, trauma, or chronic eye problem

1. __________
2. __________
3. __________
4. __________

Do you presently wear contact lenses? Yes No

Do you now or have you ever had any of the following diseases/problems? (Circle Yes or No)

Arthritis.......... Yes No
Back trouble.......... Yes No
Breathing problems.......... Yes No
Cancer.......... Yes No
If yes, year diagnosed & type __________
Cholesterol.......... Yes No
Depression/Anxiety.......... Yes No
Diabetes.......... Yes No
If yes, year diagnosed __________
Headaches.......... Yes No
Heart Stent.......... Yes No

Heart Trouble.......... Yes No
High Blood Pressure.......... Yes No
Kidney/Urinary problems.......... Yes No
Recent weight loss.......... Yes No
Sinus problems.......... Yes No
Stomach problems.......... Yes No
Stroke.......... Yes No
Thyroid problems.......... Yes No
Unusual bleeding problems.......... Yes No
Other__________

SOCIAL HISTORY

Do you have a living will? Yes No

Do you have a health care proxy? Yes No

Do you smoke? Yes No

Do you drink alcohol? Yes No

Occupation__________

Hobbies__________

MEDICATIONS (Include Vitamins/Supplements)

Medication Name, Dosage and Frequency

1. __________
2. __________
3. __________
4. __________
5. __________
6. __________
7. __________
8. __________

DRUG ALLERGIES (Include Latex)

Medication Name & Reaction

1. __________
2. __________
3. __________
4. __________
5. __________
6. __________
7. __________
8. __________

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