# MEDICAL HISTORY

## PATIENT INFORMATION

First Name:_____ Last Name:_____ Date of Birth:_____ Age:_____

Address:_____ Apt/Unit:_____ City:_____ ZIP:_____

Phone 1:_____ Phone 2:_____ E-mail: _____

## PARENT/GUARDIAN INFORMATION

Parent/Guardian:_____ Address (if different than child's): _____

Phone 1:_____ Phone 2:_____ E-mail: _____

## PRIMARY CARE PROVIDER OR PEDIATRICIAN INFORMATION

Physician Name:_____ Phone:_____ Fax:_____

Physician Address:_____ City:_____ ZIP: _____

## ALLERGIES

| Allergies | Yes | No | List specific allergies: |
|---|---|---|---|
| **Medications** | ☐ | ☐ | |
| **Other** | ☐ | ☐ | |

## SOCIAL HISTORY *(Check all that apply and provide requested information)*

| | Yes | No | How Much? | How Often? |
|---|---|---|---|---|
| **Drink Alcohol** | ☐ | ☐ | | |
| **Current Smoker** | ☐ | ☐ | | |
| **Former Smoker** | ☐ | ☐ | | |

## MEDICAL HISTORY *(Check all that apply and provide requested information)*

| | Condition | Dates | | Condition | Dates | | Condition | Dates |
|---|---|---|---|---|---|---|---|---|
| ☐ | Acid Reflux | | ☐ | Heart Defect/Disease | | ☐ | Parkinson's | |
| ☐ | Asthma | | ☐ | High Cholesterol | | ☐ | Rheumatoid Arthritis | |
| ☐ | Bleeding/Clotting Disorder | | ☐ | Hypertension | | ☐ | Sickle Cell Anemia | |
| ☐ | Cancer | | ☐ | Hyperthyroid/Hypothyroid | | ☐ | Sinusitis | |
| ☐ | COPD | | ☐ | Kidney Disease | | ☐ | Sjogren's Syndrome | |
| ☐ | Diabetes | | ☐ | Lupus | | ☐ | Skeletal Disease/Disorder | |
| ☐ | Eczema | | ☐ | Multiple Sclerosis | | ☐ | Sleep Apnea | |
| ☐ | Epilepsy | | ☐ | Muscle Disease/Disorder | | ☐ | Stroke | |
| ☐ | Headaches/Migraines | | ☐ | Osteoarthritis | | ☐ | Currently Pregnant? | Y / N |
| ☐ | *Other conditions:* | | | | | | | |

## SURGICAL HISTORY

| Surgery Type | Dates | | Surgery Type | Dates |
|---|---|---|---|---|
| | | | | |
| | | | | |
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**MEDICATION INFORMATION**

| Name of Medication | Reason for Medication | Dosage | Frequency |
|---|---|---|---|
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| | | | |
| *Other medications:* | | | |

**OCULAR HISTORY** *(Check all that apply and provide requested information)*

| | Condition | Dates | | Condition | Dates | | Condition | Dates |
|---|---|---|---|---|---|---|---|---|
| ☐ | Cataract | | ☐ | Dry Eye | | ☐ | Ptosis | |
| ☐ | Color Blindness | | ☐ | Glaucoma | | ☐ | Retinal Detachment | |
| ☐ | Conjunctivitis | | ☐ | Herpes Simplex | | ☐ | Retinitis Pigmentosa | |
| ☐ | Corneal Scar | | ☐ | Keratoconus | | ☐ | Stye | |
| ☐ | Corneal Transplant | | ☐ | Lazy Eye / Amblyopia | | ☐ | Visual Field Loss | |
| ☐ | Diabetic Retinopathy | | ☐ | Macular Degeneration | | ☐ | | |
| ☐ | Double Vision | | ☐ | Optic Neuritis | | ☐ | | |
| ☐ | *Other eye conditions:* | | | | | | | |

**FAMILY MEDICAL HISTORY** *(Check all that apply and provide requested information)*

| | Condition | Relationship | | Condition | Relationship |
|---|---|---|---|---|---|
| ☐ | Cancer | | ☐ | Macular Degeneration | |
| ☐ | Diabetes | | ☐ | Multiple Sclerosis | |
| ☐ | Glaucoma | | ☐ | Nervous System Disorder | |
| ☐ | Heart Defect/Disease | | ☐ | Optic Neuritis | |
| ☐ | High Cholesterol | | ☐ | Parkinson’s | |
| ☐ | Hypertension | | ☐ | Retinal Detachment | |
| ☐ | Hyperthyroid/Hypothyroid | | ☐ | Rheumatoid Arthritis | |
| ☐ | Lupus | | ☐ | Sickle Cell Anemia | |
| ☐ | *Other known conditions:* | | | | |