# Medical History Form

Patient Name: ______________________________________ Date: ____________

What specific visual difficulties are you experiencing now? ______________________________________

______________________________________________________________________

______________________________________________________________________

| **Do you have now or have you ever had:** | | | | If **YES**, Since when/how long? |
|---|---|---|---|---|
| A. | Diabetes, mellitus | [ ] No | [ ] Yes | ______________ |
| | If yes, duration and treatment | | | ______________ |
| B. | Heart Attack | [ ] No | [ ] Yes | ______________ |
| | Angina or Chest Pain | [ ] No | [ ] Yes | ______________ |
| | Heart Failure | [ ] No | [ ] Yes | ______________ |
| | Irregular or Rapid Heart Beat | [ ] No | [ ] Yes | ______________ |
| | A Cardiac Pacemaker Inserted | [ ] No | [ ] Yes | ______________ |
| C. | High Blood Pressure | [ ] No | [ ] Yes | ______________ |
| D. | A Stroke or "Shock" | [ ] No | [ ] Yes | ______________ |
| E. | Anemia | [ ] No | [ ] Yes | ______________ |
| F. | Asthma | [ ] No | [ ] Yes | ______________ |
| G. | Stomach or Duodenal Ulcer | [ ] No | [ ] Yes | ______________ |
| H. | Kidney Stones or Other Kidney Disease | [ ] No | [ ] Yes | ______________ |
| I. | Arthritis (if Yes, Type) | [ ] No | [ ] Yes | ______________ |
| J. | Cancer or Tumor | [ ] No | [ ] Yes | ______________ |
| | Type, Location and Date | [ ] No | [ ] Yes | ______________ |
| | Treatment Given | [ ] No | [ ] Yes | ______________ |
| K. | Thyroid Disease | [ ] No | [ ] Yes | ______________ |
| L. | Seizures or a Nervous Breakdown | [ ] No | [ ] Yes | ______________ |
| M. | Varicose Veins or Blood Clots in Legs | [ ] No | [ ] Yes | ______________ |
| N. | Other Medical Problems | [ ] No | [ ] Yes | ______________ |
| O. | Weight gain or loss more than 10 lbs in the past year? | [ ] No | [ ] Yes | ______________ |

Are you **ALLERGIC** to any medications or to any foods? [ ] No [ ] Yes ______________

**Eye Medications**: ______________________ **Other Medications:** ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

**Eye Surgery or Injury?** [ ] No [ ] Yes If Yes, please give name(s) of operation(s) or injuries and date(s) and indicate

which eye(s): ______________________________________________________________

______________________________________________________________________



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What operations other than eye surgery have you had? Please give type(s) and date(s): ______________________

______________________________________________

Do you wear glasses? [ ] No [ ] Yes   Do you wear contacts? [ ] No [ ] Yes If Yes, type of contacts _______, how long? _______

Do you smoke? [ ] No [ ] Yes   If Yes, how many per day for how many years? ______________________

If No, and you smoked in the past, how many did you smoke for how long and when did you quit? ______________________

______________________________________________

Do you consume alcohol? [ ] No   [ ] Yes   If Yes, how many drinks per week for how many years? ______________
Do you use Illegal Drugs? [ ] No [ ] Yes ______________

Occupation: ______________________ If retired, what was your occupation: ______________________

Hobbies: ______________________________________________

Do you drive? [ ] No [ ] Yes   If Yes, do you have visual difficulty when driving? [ ] No [ ] Yes

If Yes, please describe: ______________________________________________

Among your **blood relatives**, is there a history of any of the following?   If Yes, who has it?

| | No | Yes | If Yes, who has it? |
|---|---|---|---|
| Glaucoma | [ ] No | [ ] Yes | |
| Cataract | [ ] No | [ ] Yes | |
| "Lazy Eye" or muscle imbalance | [ ] No | [ ] Yes | |
| Retinal Disease | [ ] No | [ ] Yes | |
| Macular Disease | [ ] No | [ ] Yes | |
| Night Blindness | [ ] No | [ ] Yes | |
| Color Blindness | [ ] No | [ ] Yes | |
| Unexplained Visual Loss | [ ] No | [ ] Yes | |
| Diabetes Mellitus | [ ] No | [ ] Yes | |
| Tumor or Cancer | [ ] No | [ ] Yes | |
| High Blood Pressure | [ ] No | [ ] Yes | |
| Bleeding Disorder | [ ] No | [ ] Yes | |
| Blindness from Any Cause | [ ] No | [ ] Yes | |

If applicable, are you pregnant   [ ] No   [ ] Yes

**Patient Signature:** ______________________