Medical History

Patient name: _____ Date of birth: _____

Appointment date: _____ ☐ Uses wheelchair [☐can ☐cannot transfer out of chair]
Must bring attendant to push wheelchair throughout office.

To save time on your appointment day, please provide the following information. When returning this to our office, please allow sufficient time for this to arrive in our office at least 2 business days prior to your visit.

Ocular (eye) history (e.g. glaucoma, lazy eye, macular degeneration, eye surgeries): _____

_____

Past infections (e.g. hepatitis, shingles, TB): _____

_____

Current illnesses (e.g. asthma, high blood pressure, thyroid disease): _____

_____

General (non-eye, e.g. knees/hips/shoulders, heart bypass) surgery (include date): _____

_____

FAMILY HISTORY: Do any medical or eye diseases run in your family? Check box for family member with that history. Leave blank if none apply. You may add "other" diseases in the blank row.

Disease	Mother	Father	Sibling	Grandparent	Other family
Glaucoma					
Macular Degeneration					
Heart disease					
Lung disease (emphysema, COPD)					
High blood pressure					
Cancer					
Diabetes					
Other (specify)					

Allergies (include type & severity of reaction): _____

_____

List all your current prescription & non-prescription medications (include dosage and schedule):

Name of drug	Strength / Dosage	Schedule	Start date