Medical History Form

Date: _____
Patient's Name: _____ Patient's Date of Birth: _____
Patient's Occupation: _____ Patient's Hobbies: _____

Preferred Pharmacy and Location: _____
Mail Order Pharmacy: _____

Patients 13+
Tobacco Usage: **Never Smoker** **Current Smoker** **Former Smoker** **Other Tobacco**

Family Medical History:

Please check ☒ if anyone in your **FAMILY** has/had any of the following conditions as well as their relationship to you (parents, siblings, children and or grandparents- maternal and paternal)

Ocular Conditions:

Blindness: ☐ Relationship: _____
Crossed Eyes: ☐ Relationship: _____
Glaucoma: ☐ Relationship: _____
Macular Degeneration: ☐ Relationship: _____
Retinal Detachment: ☐ Relationship: _____
Retinal Disease: ☐ Relationship: _____

Other: _____

Medical Conditions:

Diabetes: ☐ Relationship: _____
Hypertension: ☐ Relationship: _____
High Cholesterol: ☐ Relationship: _____
Thyroid: ☐ Relationship: _____
Cardiovascular: ☐ Relationship: _____
Cancer: ☐ Relationship/Type: _____
_____
_____
Other: _____

Patient's Medical History:

Please check ☒ if **YOU** have/had any of the following conditions:

Ocular Conditions:

Blindness: ☐
Cataracts: ☐
Crossed Eyes: ☐
Glaucoma: ☐
Macular Degeneration: ☐
Retinal Detachment: ☐
Retinal Disease: ☐
Other: _____

Ocular Surgeries:

Cataract Surgery: Right Eye ☐ Left Eye ☐ Both Eyes ☐
Glaucoma Surgery: Right Eye ☐ Left Eye ☐ Both Eyes ☐
Lasik Surgery: Right Eye ☐ Left Eye ☐ Both Eyes ☐
Retinal Surgery: Right Eye ☐ Left Eye ☐ Both Eyes ☐
Other: _____

Past Injuries, Surgeries or Hospitalizations:

_____
_____

OVER →

Review of Systems: Please check ☒ if **YOU** have any of the following medical conditions.

General:
- ☐ Fatigue
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Fever

Ears, Nose, & Throat:
- ☐ Dry Mouth/Throat
- ☐ Ringing/Tinnitus
- ☐ Difficulty Swallowing
- ☐ Chronic Cough

Cardiovascular:
- ☐ **Heart Disease**
- ☐ **High Cholesterol**
- ☐ **High Blood Pressure**
- ☐ **Stroke**
- ☐ **Vascular Disease**

Respiratory:
- ☐ Asthma
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Other: _____

Genitourinary:
- ☐ Genital/Prostate
- ☐ Kidney/Bladder
- ☐ Ovary/Uterus/Vaginal
- ☐ STD-Viral Herpetic
- ☐ STD-Chlamydia
- ☐ Other: _____
- ☐ Pregnant ☐ Due Date: _____

Musculoskeletal:
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Arthritis
- ☐ Other: _____

Gastrointestinal:
- ☐ Chron's Disease
- ☐ Colitis
- ☐ Ulcer
- ☐ Reflux
- ☐ IBS

Skin:
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other: _____

Nervous System:
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Alzheimer's/Dementia
- ☐ Parkinson's
- ☐ Migraines/Headaches
- ☐ Traumatic Brain Injury

Mental Health:
- ☐ Depression
- ☐ Panic/Anxiety
- ☐ Mood Changes
- ☐ Pyschoses
- ☐ Amnesia
- ☐ ADD
- ☐ ADHD
- ☐ Other: _____

Endocrine:
- ☐ **Type 1 Diabetes**
- ☐ **Type 2 Diabetes**
- ☐ **Thyroid Dysfunction**
- ☐ **Hormonal Dysfunction**
- ☐ **Other**: _____

Blood/Lymphatic:
- ☐ Lyme Disease
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Leukemia
- ☐ Significant Blood Loss
- ☐ Other: _____

Cancer: Type/Year

_____
_____
_____
_____

Allergies:
- ☐ Seasonal Allergies

Food Allergies:

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Drug Allergies:

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Current Medications:

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Vitamins/Supplements:

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