# MEDICAL HISTORY INFORMATION SHEET

**Name:** ________________________ **D.O.B:** __/__/__ **Today's Date:** __/__/__
**Reason For Today's Visit:** ________________________________________________

**Medical History: Please check any illness/condition YOU have.**

__Allergies __Anemia __Arthritis __Asthma __Cancer __Depression

__Diabetes __Headache __Heart Issues __Hepatitis __High Blood Pressure

__High Cholesterol __Mental Illness __Seizures __ Stroke __Thyroid Disease

Please list any other conditions you have:________________________________________

**Eye History: Please check any illness/condition YOU currently have.**

__Blindness __Blurred Vision __Burning __Cataracts __Discharge

__Double Vision __Dryness __Flashes of Light __Floaters __Glare/Halos

__Itching __Light Sensitivity __Poor Night Vision __Red Eyes __Watering

Please list any other eye conditions you have:______________________________________

**Eye Surgery History: Please list any prior Eye Surgeries you have had.**

______________________________________________________________________

**Family Eye History: Please check if your immediate family has ever had.**

__Blindness __Cataracts __Diabetes __Glaucoma __Macular Degeneration

**Social History: Please Check All That Applies.**

Tobacco Use: __Never __Former __Current List Type:______________________

Alcohol Use: __Never __Frequent __Social List Type:______________________

Drug Use: __Never __Former _Current List Type:______________________

**Allergic To Latex: __Yes __No** **Allergy to Meds: __Yes __NO**

Please List Drug Allergies: ______________________________________________

**Current Medications: Please List ALL Current Medications You Are Taking:**

______________________________________________________________________

______________________________________________________________________

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