Confidential Medical History Form

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PATIENT NAME: ____ DATE: ______________

1. Please list all <u>medications</u> you take on a regular basis:

(Please include any eye drops, vitamins, herbs, or over the counter products such as aspirin or aspirin containing products.)

<u>Medication</u> <u>Strength</u> <u>Frequency</u>

1.____

2.____

3.____

4.____

5.____

6.____

2. Please list all <u>illnesses/diseases</u> which you have had or have now:

1.____

2.____

3.____

4.____

5.____

6.____

3. Please list all prior <u>surgeries or procedures</u>:

<u>Surgery</u> <u>Physician</u> <u>Approximate Date</u>

1.____

2.____

3.____

4.____

5.____

4. Please list any <u>allergy or sensitivity</u> to medication or food:

<u>Medication</u> <u>Reaction</u>

1.____

2.____

3.____

Patient Name:____

5. Has anyone in your family had the same problem that brings you to our office?

[ ] Yes [ ] No If yes, who? ___________________________________

Do any of these diseases run in your family. If YES, please note relationship.

__Glaucoma ____________________
__Diabetes ____________________
__High blood pressure_____________
__Skin cancer ____________________
__Other __________________________

Do you smoke? If YES, how much?
____

Drink alcohol? If YES, how much?
____

6. Do any of the following problems apply to you? If YES, please explain.

Constitutional (fever, weight loss, poor appetite, etc.)	□ yes □ no	
Eyes (glaucoma, cataract, lazy eye, retina problems, etc)	□ yes □ no	
Ear/Nose/Throat (hearing loss, sinus problems, sore throat, frequent bloody noses, etc)	□ yes □ no	
Cardiovasc (heart problems, chest pain, high blood pressure, stroke, pacemaker, heart surgery)	□ yes □ no	
Respiratory (asthma, shortness of breath, wheezing, coughing, etc)	□ yes □ no	
Gastro-intestinal (heartburn, diarrhea, vomiting, abdominal pain, etc)	□ yes □ no	
Genito-urinary (urinary problems, blood in urine, etc)	□ yes □ no	
Skin (skin rashes, excessive dryness, used accutane, skin cancer/diseases, etc)	□ yes □ no	
Musculoskeletal (muscle aches, joint pain, swollen joints, artificial joint, arthritis, etc)	□ yes □ no	
Neurological (numbness, weakness, paralysis, headaches, spasm, MS, etc)	□ yes □ no	
Hematologic (blood disorders, leukemia, easy bleeding/bruising, take aspirin, etc)	□ yes □ no	
Allergy (hay fever, seasonal allergies, etc)	□ yes □ no	
Endocrine (thyroid or pituitary problems, etc)	□ yes □ no	
Psychiatric (depression, anxiety, etc)	□ yes □ no	
Hepatitis B or C, HIV or AIDS, Tuberculosis, etc	□ yes □ no	
Diabetes, radiation treatments, anesthesia problems, etc.	□ yes □ no	

Other Comments:____

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Physician Initials ________ Date ________