MEDICAL HISTORY

Name: ______________________________ Birth Date: ______________________

Address: ____

City: ______________________ State: ______________ Zip: ______________

Phone: (h) ____________________ (w) ____________________ (c) ____________________

(Please circle the telephone number where we can best reach you or leave a message).

Primary Care Physician: ____

Do you have allergies to any medications? ❑ YES ❑ NO

If YES, list the medications you are allergic to: ______________________________

____

____

PATIENT - PAST MEDICAL HISTORY		
	YES	NO
Allergies		
Asthma		
Arthritis		
Depression		
Diabetes Type 1 or Type 2		
GERD		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Liver Disease		
Migraine		
Osteoporosis		
Seizure Disorder		
Thyroid Disease		
Other		

FAMILY - PAST MEDICAL HISTORY			
	YES	RELATION	NO
Asthma			
Cardiovascular Disease			
Depression			
Diabetes Type 1 or Type 2			
Cancer: Type			
Kidney Disease			
Migraines			
High Blood Pressure			
Osteoporosis			
Seizure Disorder			
Stroke			
Thyroid Disease			
Macular Degeneration			
Glaucoma			
Cataracts			
Other			

SOCIAL

Current Employer/Student: ____

Minor ❑

Marital Status ❑ Single ❑ Divorced ❑ Widowed ❑ Married Spouse Name: ____________________

Do you drive? ❑ YES ❑ NO

Do you have visual difficulty when driving? ❑ YES ❑ NO

Do you have problems with night vision? ❑ YES ❑ NO

Do you drink alcohol? ❑ YES ❑ NO If yes: ❑ 1/day ❑ 2-3/day ❑ 4+/day ❑ Occasional

Do you smoke? ❑ YES ❑ NO Type ____________________

Are you a previous smoker? ❑ YES ❑ NO How long did you smoke? ____________________

When did you quit? ____________________ How much did you smoke? ____________________

Were you exposed to passive smoke? ❑ YES ❑ NO