MEDICAL HISTORY

Name: _____ Birth Date: _____

Primary Care Physician: _____

Current Medications (or copy of list): _____

_____

_____

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

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

_____

Past Surgeries: _____

_____

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