PATIENT MEDICAL HISTORY FORM:

Patient Name _____ Date _____

▪ GENERAL MEDICAL HISTORY:
Please mark if you have or had the following:

_____ High Blood Pressure
_____ Arthritis
_____ Heart Trouble
_____ Stroke
_____ Migraine Headaches
_____ Stomach Ulcers
_____ Immune Deficiency Disease
_____ Tuberculosis
_____ Cancer: _____
_____ Emphysema
_____ Diabetes Last blood sugar _____
_____ Thyroid Disease
_____ Kidney Disease
_____ Liver Disease
_____ Hepatitis
_____ Other: _____

☐ **MEDICATIONS**	**▪ DOSAGE**	**▪ HOW OFTEN**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you **ever** taken Flomax? ☐ Yes ☐ No

▪ DRUG ALLERGIES AND REACTIONS:

_____ _____
_____ _____

YOUR EYE HISTORY: Please mark if you have any of the following

_____ Cataracts
_____ Retinal Disease
_____ Double Vision
_____ Contact Lens Wearer (Hard or Soft)
_____ Macular Degeneration
_____ Glaucoma
_____ Dry Eye
_____ Any Other Disorder _____

Please List Any Eye Surgeries and When:

_____
_____

SURGICAL HISTORY AND HOSPITALIZATIONS WITHIN THE LAST YEAR:

_____
_____

FAMILY HISTORY: **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply) ☐ Yes ☐ No ☐ Unknown

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Any other inheritable disease:

SOCIAL HISTORY:

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ How many years?