



## Your Medical, Surgical, Family and Personal History

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood pressure \_\_\_\_\_ BMI \_\_\_\_\_

### Personal History

Do You Smoke? Y/N \_\_\_\_\_ Do You Drink Alcohol? Y/N \_\_\_\_\_ Recreational Drug Use? Y/N \_\_\_\_\_ Caffeine? Y/N \_\_\_\_\_  
 Hearing Impaired? Y/N \_\_\_\_\_ Reading impaired? Y/N \_\_\_\_\_ **Any special needs requiring assistance? Y/N** \_\_\_\_\_

### Ocular History (check all that apply for self) **Date of Last Eye exam?** \_\_\_\_\_

Decrease in Vision \_\_\_\_\_ Itchy or Dry eyes \_\_\_\_\_ Red Eyes \_\_\_\_\_ Amblyopia (lazy eye) \_\_\_\_\_  
 Discharge from Eyes \_\_\_\_\_ Flashes of light or floaters \_\_\_\_\_ Double Vision \_\_\_\_\_ Retinal Detachment \_\_\_\_\_  
 Eye discomfort \_\_\_\_\_ Macular Degenerations \_\_\_\_\_ Cataracts \_\_\_\_\_ Glaucoma \_\_\_\_\_

### Medical History (check all that apply for self)

Arthritis _____	Thyroid Disease _____	HIV _____	Keratoconus _____
Migraine _____	Hypertension _____	Cancer _____	Blindness _____
Emphysema _____	Skin condition _____	Diabetes _____	Dementia _____
Stroke _____	Heart Disease _____	Lupus _____	Bruise/Bleed easily _____
Chrones Disease _____	Colitis _____	Other _____	

### Family History (label as the following if applicable: F for father, M for mother, S for sibling, G for grandparent)

Arthritis _____	Thyroid Disease _____	HIV _____	Keratoconus _____
Migraine _____	Hypertension _____	Cancer _____	Blindness _____
Emphysema _____	Skin condition _____	Diabetes _____	Dementia _____
Stroke _____	Heart Disease _____	Lupus _____	Bruise/Bleed easily _____
Chrones Disease _____	Colitis _____	Other _____	

### Surgical History List all **Past Surgeries, including Eye Surgery** and Significant Injuries (Date)

\_\_\_\_\_  
 \_\_\_\_\_

### Current Medications

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Drug Allergies & Reactions

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Signature and Date: \_\_\_\_\_