Medical History Form

Name: _____

Primary Purpose of this visit: _____

Email: _____

Please Circle if you have or have had any of the following:

Constitution

Developmental disabilities

Cancer

Fatigue Syndrome

Ears, Nose & Throat

Hearing Loss

Sinusitis

Dry mouth

Laryngitis

Neuro

Multiple Sclerosis

Epilepsy

Cerebral Palsy

Tumor

Stroke

Migraine

Psych

Depression

ADHD

Anxiety Disorder

Bipolar Disorder

Cardiovascular

High Blood Pressure

Stroke

Heart Disease

Vascular Disease

Congestive Heart Failure

Respiratory

Smoker

Asthma

Bronchitis

Emphysema

COPD

Sleep Apnea

GI

Crohn's Disease

Colitis

Ulcer

Acid Reflux

Celiac Disease

GU

Kidney Disease

Prostate Disease/Cancer

STD

BPH

Currently Pregnant

Currently Nursing

Herpes

Chlamydia

Muscular/ Skeletal

Osteoarthritis

Fibromyalgia

Muscular Dystrophy

Ankylosing Spondylitis

Osteoporosis

Gout

Integumentary

Eczema

Rosacea

Herpes Simplex/ Cold Sore

Shingles

Endocrine

Type 2 Diabetes

Type 1 Diabetes

Thyroid Dysfunction

Hormonal Dysfunction

Hem/Lymph

Anemia

Large Volume Loss

Ulcer

High Cholesterol

Allergy/ Immunology

Drug Allergies

Environmental Allergies

Rheumatoid Arthritis

Lupus

Sjögren's Syndrome

PLEASE TURN OVER

List of Current Medications: **NONE** **UNSURE**

_____

_____

Medication Allergies: **YES** **NO**
If 'Yes', Name of Medications:

_____

Latex sensitivity: **YES** **NO**

Past Ocular History:

Glaucoma	Amblyopia	Retinal Degeneration
Glaucoma Suspect	Patching	Keratoconus
Cataract	Inflammatory Disorder	Injury to Eye
Macular Degeneration	Strabismus	Surgery on Eye
Dry Eye	Nystagmus	Other: _____

Current Vision Correction: **Glasses** **Contact Lenses** **None**

Interested in Contacts: **YES** **NO**

Social History:

Drinking: **YES** **NO** Amount: _____

Tobacco: **YES** **NEVER** **FORMER** Amount: _____

Last Eye Exam: _____ **Where:** _____

Primary Care Doctor: _____

Referred by: _____

Employment: _____ **Position:** _____