

Medical History

Patient Name: _____

Please list any medications you are taking:

Please list any ALLERGIES to medications you are aware of:

Family Medical Doctor _____

Name of Last Eye Doctor _____ Date of last exam _____

Check all that apply to YOUR HISTORY

ALLERGIC

Seasonal Allergies ___
Itchy Eyes ___
Chronic Sinus ___

NEUROLOGICAL

Headaches ___
Migraines ___
Head Trauma ___

MEDICAL

Diabetes ___
Hypertension ___
Cholesterol ___
Heart ___
Arthritis ___
Thyroid ___
Other _____

EYE HEALTH HISTORY

Glaucoma ___
Cataracts ___
Past Eye Surgery ___
Past Eye Injury ___
Retina/Macular ___
Dry Eye ___
Other _____

Additional Personal Medical/Eye History _____

Check all that apply to your FAMILY HISTORY

EYE FAMILY HISTORY

Glaucoma ___ Who _____
Retinal Detachment ___ Who _____
Macular Degeneration ___ Who _____

Addition Family Eye History _____
