PATIENT MEDICAL HISTORY FORM

Please CIRCLE all of the following the YOU have or currently experience:

Eyes
- Blurred Vision
- Double Vision
- Vision Loss
- Flashes of Light
- Floaters
- Distorted Vision
- Eye Pain
- Eye Swelling
- Redness or Discharge
- Light Sensitivity
- Tired Eyes
- Cataracts
- Glaucoma
- Macular Degeneration
- Dry Eyes

Allergies/Immune
- Seasonal Allergies
- Autoimmune Disease

Cardiovascular
- High Blood Pressure
- Stroke

Endocrine
- Diabetes
- Thyroid Disease
- Kidney Disorder

Neurological
- Migraines/Headaches
- Seizures
- Multiple Sclerosis
- Dementia

Musculoskeletal
- Arthritis
- Myasthenia Gravis

Integumentary
- Rosacea
- Cancer

Respiratory
- Asthma
- Shortness of Breath
- Emphysema
- COPD

Hematological/Lymphatic
- Elevated Cholesterol
- Swollen Lymph Nodes

Ear/Nose/Throat
- Sinus Problems
- Dry Mouth
- Chronic Ear Infections
- Sjogren's Disease

Gastrointestinal
- Crohn's Disease
- IBS

Psychiatric
- Nervous Disorder
- Depression
- Anxiety
- ADHD

Constitution
- Fever
- Weight Loss/Gain

Height: _____ Weight:_____ **Tobacco Use:** Current Smoker ☐ Former Smoker ☐ Never Smoker ☐

Please list current medications you are taking (or attach list):

_____FOR_____
_____FOR_____
_____FOR_____
_____FOR_____

Please list any drug allergies:

_____
_____
_____

Does anyone in your family have the following?

Glaucoma	Y	N	Lazy Eye	Y	N
Macular Degeneration	Y	N	Retinitis Pigmentosa	Y	N
Diabetes	Y	N	Other	Y	N

Are you seeing any specialists for your eyes? Y N If yes, why _____

List any past eye surgeries, eye conditions or eye injuries: