

PATIENT MEDICAL HISTORY

NAME: _____ BIRTHDATE: _____ SEX: M / F

Do you have a family doctor **YES** or **NO**? If yes, please list _____

REVIEW OF SYSTEMS:

Please mark the box if you have any of the following:

- | | | | | | |
|--|--|--|--|--|-----------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Muscle/Joint pain | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Sinus Problem | <input type="checkbox"/> Stroke/TIAs | <input type="checkbox"/> Cough | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Fever | <input type="checkbox"/> Rashes | <input type="checkbox"/> Depression | <input type="checkbox"/> Rosacea |

Other, please specify: _____

Explain any problems checked above: _____

FAMILY HISTORY:

Do any medical or eye diseases run in your family? Circle **YES** or **NO**. If yes, please circle all that apply:

GLAUCOMA CATARACTS MACULAR DEGENERATION CANCER
DIABETES HEART DISEASE HIGH BLOOD PRESSURE OTHER: _____

SOCIAL HISTORY:

Do you smoke/ use tobacco? (Circle One) **YES** or **NO**. If yes, how much? _____

Do you drink alcohol? (Circle One) **YES** or **NO**. If yes, how much? _____

List **ALL MEDICATIONS** (including eye medications) **you are currently taking**. (We will be happy to copy your list, if you have one.)

Please include prescription and over-the-counter medications; including vitamins, pain relievers, herbal remedies, etc.

HAVE YOU EVER TAKEN FLOMAX ? YES or NO (ARE YOU TAKING IT NOW? YES or NO)

List any/All Eye Surgeries/Diseases/Traumas you have had:

List All Surgeries (excluding eye): _____

Any Allergies to Food and/or Drugs: (Circle One) **YES** or **NO**. If yes, please list: _____

Are you allergic to Adhesive Tape? (Circle One) **YES** or **NO**

Are you allergic to any Latex? (Circle One) **YES** or **NO**

Are you **CLAUSTROPHOBIC**? (Circle One) **YES** or **NO**

Do you have Sleep Apnea? (Circle one) **YES** or **NO**

SIGNATURE: _____ **DATE:** _____