

History and Physical Information

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Date of last medical exam: _____

Primary Care Physician: _____ Phone: _____

Do you have any allergies to medications? Yes No If yes, please explain

Current Medications: (if you have a list we would be happy to make a copy)

Please list any previous surgeries and year: _____

Please comment if applicable:

Heart Problem: Heart Attack, what year _____ Irregular Heartbeat

Murmur Pacemaker other: _____

High blood pressure: Stroke when? _____

Lungs: Asthma Emphysema/COPD Bronchitis TB

Seasonal allergies: other: _____

Liver Disease: Hepatitis: type _____ Jaundice other: _____

Kidneys: Dialysis Transplant

Diabetes: Diet Control Oral Meds Insulin Insulin Pump

Other: _____

Digestive Disorders: Ulcer Hiatal Hernia Acid Reflux Other: _____

Arthritis Bleeding Disorder

Have you ever been exposed or infected with: Gonorrhea Hepatitis HIV Syphilis none

If female of childbearing years: I am not pregnant I am pregnant

Possibility that I am pregnant

Family History

Please note any family history (parents, grandparents, siblings, children (living or deceased) of the following: Please specify family member in space provided.

Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Retinal Detachment/Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Please Circle any of the following you have had:

crossed eyes lazy eye drooping eyelid prominent eyes glaucoma
retinal disease cataracts eye infections eye injury

Please Comment if Applicable:

I have: Contacts. When was the last time you wore contacts? _____
I have: Glasses. How old is your current pair of lenses? _____
I smoke: Cigarettes Cigar Pipe How much and for how long? _____
I drink alcohol: Daily Weekly occasionally