MEDICAL HISTORY

The status of your general health is important in evaluating problems you may have with your vision and your eyes. Please complete this form prior to seeing your doctor.

NAME_______________________________ **AGE**______ **OCCUPATION**____________________

List any **medications** you currently take (prescription and over-the-counter) ______________ ______________

______________ ______________ ______________ ______________ ______________

Have you ever taken ***Flomax*** _____ **YES** _____ **NO**

Do you have **allergies** to any medications? _____ **YES** _____ **NO** If **YES**, list the medications ______________

______________ ______________ ______________ ______________ ______________

Have you ever had the following? Please check **YES** or **NO** for each item indicated.

YES	NO		YES	NO		YES	NO	
______	______	Diabetes	______	______	Stroke	______	______	Seasonal Allergies
______	______	High Blood Pressure	______	______	Seizure	______	______	Kidney Disease
______	______	Heart Disease	______	______	Arthritis	______	______	Chronic Bronchitis/Asthma
______	______	Anemia	______	______	Cancer	______	______	Stomach/GI Ulcer
______	______	Thyroid Disease	______	______	Liver Disease (Hept B or C)	______	______	Premature Birth
______	______	Prostate Problems	______	______	Tuberculosis			
______	______	HIV	______	______	Bleeding Problems			

Provide current status of above or other known conditions:______________________________

____

List any **surgeries** you have had (cataract, appendectomy, heart by-pass, etc.)______________________________

____

Do you **currently** have any problems in the following areas? If "**YES**", please **CIRCLE SYMPTOMS**

	YES	NO		YES	NO
GENERAL CONSTITUTIONAL fever, weight loss, poor appetite, fatigue			**SKIN** rash, itching, skin cancer, acne		
EARS, NOSE, THROAT hearing change, nasal blockage, mouth sores			**NEUROLOGICAL** headaches, weakness, loss of balance, tingling		
HEART chest pain, palpitations, swelling, blackouts			**PSYCHIATRIC** anxiety, depression, hallucinations, insomnia		
LUNGS shortness of breath, cough, wheezing			**ENDOCRINE** excessive thirst, sweats, chills, malaise		
GASTROINTESTINAL heartburn, nausea, diarrhea, bloody stool			**BLOOD/LYMPH, HIGH CHOLESTEROL** bruising, bleeding, swollen glands, anemia		
GENITAL, KIDNEY, BLADDER frequent urination, blood in urine, infections			**ALLERGIC/IMMUNOLOGIC** hayfever, sinus congestion, nasal drip		
MUSCLES, BONES, JOINTS stiffness, swelling, back pain, arthritis, lupus			**PREGNANT**		

FAMILY HISTORY: M=MOTHER, F=FATHER, S=SIBLING, GP=GRANDPARENT

DISEASE	YES	NO	FAMILY MEMBER	DISEASE	YES	NO	FAMILY MEMBER
Blindness				Diabetes			
Glaucoma				Retinal Detachment			
Macular Degeneration				Cataracts			
				Lazy Eye			
Cancer				Thyroid			

Do you drink alcohol? ____**YES** ____**NO** **If yes, circle answer: occasional almost daily abuse**

Do you smoke? ____**YES** ____**NO** If yes, circle answer: **past currently 1/2 pk a day 1 pk a day 1+ pk a day**

CURRENT EYE PROBLEM: NONE_____ VISION_____ OTHER______________________________

PATIENT SIGNATURE______________________________**DATE:**__________________

The above is true and correct to the best of my knowledge.

PHYSICIAN'S SIGNATURE______________________________**DATE:**__________________