Medical History Form

Patient Name: _____ **Date of Birth:** _____ **Date of Appointment:** _____

1. Medical & Eye History:

Have you ever been treated for any medical conditions? (e.g., diabetes, high blood pressure, arthritis)
☐ YES ☐ NO If YES, provide details: _____

Have you ever had any eye disease? (e.g., glaucoma, cataracts, lazy eye)
☐ YES ☐ NO If YES, provide details: _____

Have you had any surgeries?
☐ YES ☐ NO If YES, provide details: _____

Do you take medications?
☐ YES ☐ NO If YES, pls list: _____

Do you have drug allergies?
☐ YES ☐ NO If YES, provide details: _____

2. System Review - Check any current or past problems:

Condition	**YES**	**NO**
Heart / Chest	☐	☐
Lungs / Breathing	☐	☐
Ear / Nose / Throat	☐	☐
Gastrointestinal	☐	☐
Urinary	☐	☐
Skin	☐	☐
Muscles / Joints	☐	☐
Neurologic (numbness, headache)	☐	☐
Psychiatric (anxiety, depression)	☐	☐
Chronic fever / fatigue / weight change	☐	☐

3. Family History: Any family history of medical or eye conditions? (e.g., diabetes, high blood pressure, glaucoma)
☐ YES ☐ NO If YES, provide details: _____

4. Lifestyle: Do you smoke? ☐ YES ☐ NO | How much? _____ Age started: _____ Age quit: _____
Do you drink alcohol? ☐ YES ☐ NO How much? _____

5. Contacts: Primary Care Physician: _____ Phone: _____
Emergency Contact name: _____ Relationship: _____ Phone: _____
Pharmacy name and address: _____ Phone: _____

Reviewed by (Physician Signature): _____
Date: _____