CONFIDENTIAL PATIENT MEDICAL HISTORY PROFILE

DATE: __________

The following information is very important to your health. Please take the time to fully complete this form.

Name: ____ DOB: ___________

Sex: Male ☐ Female ☐ Height: ________ Weight: ________ Last Hemoglobin AIC: ______

Employer: ______________________________ Occupation: ___________________________

Job Physical Function: ex: lifting-bending ____

REASON FOR TODAY'S VISIT					
	Cataract		Diabetic Exam		Increased Tearing
	Dry Eyes		Flashes		Floaters
	Driving Difficulty(day/night)		Decreased Vision		Other
Would you like to be checked for a new eye glass prescription today? Yes No					

Is your current problem injury related? ☐ Yes ☐ No If yes, date of injury: _____________

Cause of injury: ☐ Work Accident ☐ Auto Accident ☐ Home Accident ☐ Sports Activity
☐ Other ____

History of Present Problems/Illness: (please describe the your current problem)

____

____

MEDICAL HISTORY: Please check the YES or NO box

Yes	No		Yes	No	
		Heart Disease			Diabetes
		Cancer/Type:			Thyroid Disease
		Mitral Valve Prolapse			High Blood Pressure
		Rheumatoid Arthritis/Lupus			Kidney Disease
		Problem with Anesthesia			Hepatitis/Liver Disease
		Ulcers/Stomach Problems			HIV/AIDS
		Hemophilia/Bleeding Problems/Anemia			Epilepsy/Seizures
		Nervous/Mental Disorder/Depression			Cholesterol
		Usual Childhood Disease (mumps,measles,etc.)			Venereal Disease
		Blood Clot/DVT/Pulmonary Embolus			Asthma/Respiratory Disease/TB
		Other			

CONTINUE ON BACK

PAST MEDICAL SURGICAL HISTORY (LIST TYPES OF SURGERY):

1.	3.	5.
2.	4.	6.

PAST EYE PROBLEMS/DISEASES:

1.	3.	None ☐
2.	4.	

PAST EYE SURGICAL HISTORY (LIST TYPES OF SURGERY):

1.	3.	5.
2.	4.	6.

FAMILY EYE HISTORY (CHECK ANY THAT APPLY TO YOUR FAMILY HISTORY):

☐ Glaucoma	☐ Diabetes	☐ Corneal Problems
☐ Macular Degeneration	☐ Cataract	☐ Adopted
☐ Unknown		

DO YOU DRIVE? ☐ No ☐ Yes; If so, ☐ Daylight only ☐ Both day & nighttime driving

SOCIAL HISTORY
☐ MARRIED
☐ SINGLE
☐ DIVORCED
☐ WIDOW
☐ DOMESTIC PARTNER
☐ CIVIL UNION
☐ LIVES ALONE

ALCOHOL USE
☐ 1-2 DRINKS/DAY
☐ 1-2 DRINKS/WEEK
☐ 3+ DRINKS/DAY
☐ RARELY DRINKS
☐ NEVER DRINKS

TOBACCO USE	
☐ CURRENT SMOKER	
	# OF YEARS
	# PACKS/DAY
☐ CHEW/SNUFF	
☐ NEVER SMOKED	
☐ FORMER SMOKER	
	YEAR QUIT

LIST OF MEDICATION ALLERGIES:

1.	2.	3.

PLEASE LIST RECREATIONAL DRUG USE:____

THE ABOVE INFORMATION IS CORRECT AND WAS FILLED OUT TO THE BEST OF MY ABILITY:

Patient Signature:____ **Date:** _____________________

(Parent signature if patient is a minor)