

# Medical History

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Medications	Allergies
List any medications you are currently taking, including eye drops: _____ _____ _____ _____	List your allergies to medications or other substances: _____ _____ _____ _____

Surgeries	Family History
List all surgeries you have had in the past: _____ _____ _____	List any diseases that run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration) _____ _____ _____

General/Constitutional			
Do you currently have any of the following problems:	Yes	No	If YES please explain
<b>Ear/nose/throat</b> (hearing loss, sinus, sore throat) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Cardiovascular</b> (irregular blood pressure, chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Respiratory</b> (shortness of breath, wheezing, coughing) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Gastrointestinal</b> (heartburn, abdominal pain, diarrhea, vomiting)..	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Urinary</b> (pain or discomfort, blood in urine) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Skin</b> (rashes, excessive dryness) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Musculoskeletal</b> (muscle aches, swollen or painful joints) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Neurological</b> (numbness, paralysis, headaches).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Psychiatric</b> (depression, anxiety) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Other</b> (unexplained weight loss, fever, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have diabetes? yes no If yes, how many years? \_\_\_\_\_

Is your visit here related to a work injury? yes no

Do you smoke? yes no If yes, how much? \_\_\_\_\_

Do you drink alcohol? yes no If yes, how much? \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_