

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
Ear/nose/throat (hearing loss, sinus, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (irregular blood pressure, chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)..	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary (pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (muscle aches, swollen or painful joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological (numbness, paralysis, headaches).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (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 _____