Medical History Form

Patient Name: ____ _______________

Section A:

Have you had any injuries to your eyes? ☐ Yes ☐ No
Have you had a lazy eye? ☐ Yes ☐ No
Have you had a detached retina? ☐ Yes ☐ No
Have you had any prior eye surgeries? ☐ Yes ☐ No
Have you had any prior surgeries? ☐ Yes ☐ No
Has a family member had cataracts? ☐ Yes ☐ No
If yes, who? ____
Has a family member had glaucoma? ☐ Yes ☐ No
If yes, who?:____
Has a family member had a detached retina? ☐ Yes ☐ No
If yes, who? ____
Has a family member had any other eye disease? ☐ Yes ☐ No
If yes, please explain: ____-
____

Section B:

Please check all conditions that apply to your health

☐ Recent fever
☐ Weight loss
☐ Cancer
☐ Heartbeat problems
☐ Chest pain
☐ Asthma
☐ Emphysema
☐ Breathing problems
☐ Hepatitis
☐ Psoriasis
☐ Diabetes
☐ Thyroid disease
☐ High Cholesterol
☐ Depression
☐ Nervous problems
☐ Arthritis
☐ Joint pain
☐ High blood pressure
☐ Bleeding problems
☐ Stroke
☐ Ulcers
☐ Kidney stones
☐ Liver problems
☐ Headaches
☐ Sinus problems
☐ Crohns disease
☐ Ulcerative colitis
☐ Cortisone shots/cream
☐ Eczema
☐ Heart attack

Other conditions not listed above: ____
____

Section C:

List all medications you are taking orally: ____
____
____
Are you allergic to any medication? ☐ Yes ☐ No
If yes, what medication? ____
Do you smoke? ☐ Yes ☐ No
If yes, how many packs per day? _________________________________
Do you drink alcohol? ☐ Yes ☐ No
If yes, how much and how often? _________________________________
What is your current or previous occupation? _________________________
Do you need help taking medication or using eye drops? ☐ Yes ☐ No
Do you have mobility problems? ☐ Yes ☐ No

Patient signature: ____________________________________ **Date:** ________________

- To be completed by Yaldo Eye Center doctor or staff -

Follow-up exam: _____________ **History reviewed:** ______________________________