Health and Medications Information

DOB: _____

Name: _____

Family Physician: _____

DRUG ALLERGY / Reaction: _____

_____

Date: _____

Phone: _____

Referring Doctor: _____

Preferred Pharmacy: _____

Current Medications Dosage / Frequency

Surgical Procedures within last 5 years

YOUR PAST MEDICAL HISTORY

- ☐ Acid Reflux Disease (GERD)
- ☐ Alzheimer's Disease
- ☐ Anemia - Chronic
- ☐ Arthritis - Degenerative (DJD)
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ COPD -Chronic Lung Disease
- ☐ CVA - Stroke
- ☐ Cancer _____
- ☐ Cirrhosis / Liver Disease
- ☐ Collagen Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ DVT - Deep Vein Thrombosis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes #years_____
- ☐ Dialysis - Hemodialysis
- ☐ Diverticulitis
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Graves's Disease
- ☐ HIV / AIDS
- ☐ Other:_____
- ☐ Head Injury
- ☐ Headache - Chronic
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hepatitis B / C
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Malignant Hyperthermia
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pain - Chronic
- ☐ Peptic Ulcer Disease (PUD)
- ☐ Peripheral Vascular Disease
- ☐ Prostate Enlarged (BPH)
- ☐ Renal Insufficiency - Chronic
- ☐ Restless Legs Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Vertigo
- ☐ Anticoagulant Therapy
- ☐ Other:_____
- ☐ Other:_____

Eye Problems	Self	Family	
Amblyopia (Lazy Eye)	☐	☐	_____
Glaucoma	☐	☐	_____
Astigmatism	☐	☐	_____
Cataract	☐	☐	_____
Choroidal Melanoma	☐	☐	_____
Corneal Dystrophy	☐	☐	_____
Diabetic Retinopathy	☐	☐	_____
High Myopia	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Strabismus	☐	☐	_____
Other:	☐	☐	_____
	☐	☐	_____
	☐	☐	_____

Family Medical Problems

Complication of Anesthesia _____
Bleeding (Coagulation) Disorder _____
Cancer _____
Diabetes _____
Heart _____
Hypertension _____
Migraine _____
Rheumatoid Arthritis _____
Stroke _____
Thyroid Disorder _____
Other: _____

YOUR SOCIAL HISTORY

	Y	N	Frequency / Type
Do you smoke?	☐	☐	_____
Do you drink alcohol?	☐	☐	_____
Do you use recreational drugs?	☐	☐	_____

Please indicate special living arrangements below:

☐ Nursing home ☐ Skilled nursing facility/floor ☐ Other _____

Name of facility _____

	Y	N
Are you currently pregnant?	☐	☐
Advanced directive / Living Will?	☐	☐