MEDICAL HISTORY FORM

[ ] Initial Hx

[ ] Updated Hx

1. Name:_____ Date:_____

2. Do you have now, or have you ever had: Date of Onset:

a. Diabetes Mellitus..... YES___ NO___ _____
Treatment: diet control___ oral agents___ Insulin___
Medical Complications: renal___ neuropathy___ vascular___ other___

b. Heart attack..... YES___ NO___ _____
Angina or chest pain..... YES___ NO___ _____
Heart failure..... YES___ NO___ _____
Irregular or rapid heart beat..... YES___ NO___ _____
A cardiac pacemaker inserted .... YES___ NO___ _____

c. High blood pressure ..... YES___ NO___ _____

d. A stroke or "shock" ..... YES___ NO___ _____

e. Anemia..... YES___ NO___ _____

f. Asthma ..... YES___ NO___ _____
Emphysema and/or bronchitis .... YES___ NO___ _____
Pneumonia..... YES___ NO___ _____
Tuberculosis ..... YES___ NO___ _____

g. Liver disease or jaundice..... YES___ NO___ _____

h. Stomach or duodenal ulcer ..... YES___ NO___ _____

i. Kidney stones or other kidney disease YES___ NO___ _____

j. Arthritis (if yes, type) ..... YES___ NO___ _____

k. Cancer or tumor..... YES___ NO___ _____
Type, location, and date _____
Treatment given _____

l. Thyroid disease ..... YES___ NO___ _____
Underactive _____ Treatment _____
Overactive _____ Treatment _____

m. Seizures or a nervous breakdown .. YES___ NO___ _____

n. Varicose veins or blood clots in legs YES___ NO___ _____

o. Bleeding disorders..... YES___ NO___ _____

p. Transfusions of blood or plasma... YES___ NO___ _____

q. AIDS, ARC, or HIV positive test .... YES___ NO___ _____

r. Other medical problems ..... YES___ NO___ _____

3. Are you allergic to any medications or to any foods? YES___ NO___
If yes, please describe substance(s), with date and type of reaction:
_____

4. a. What eye medications are you using at present? Give name(s) and dosage:
_____
_____

b. What other medications do you take regularly? Please give name(s) and dosage:
_____
_____
_____

When did you last use aspirin, in any form? _____

5. Have you had any previous eye surgery/laser, or injuries? YES___ NO___

   If yes, please give name(s) of operation(s) or injuries and date(s):

   _____

   _____

6. What non-ocular operations have you had? Please give type(s) and date(s):

   _____

   _____

   Date of last general anesthesia _____ Any anesthesia complication? YES___ NO___

7. Are you a smoker? YES___ NO___

   If yes, how many cigarettes per day? _____

   If no, and you smoked in the past, when did you stop? _____

8. Have you gained or lost more than ten pounds in the past year? YES___ NO___

   If yes, how many pounds have you gained _____ or lost _____; please explain:

   _____

9. Among your blood relatives, is there a history of any of the following:

a. Glaucoma	YES___	NO___	_____
b. Cataracts	YES___	NO___	_____
c. "Lazy eye" or muscle imbalance	YES___	NO___	_____
d. Retinal disease	YES___	NO___	_____
e. Macular disease	YES___	NO___	_____
f. Night blindness	YES___	NO___	_____
g. Color blindness	YES___	NO___	_____
h. Unexplained vision loss	YES___	NO___	_____
i. Diabetes mellitus	YES___	NO___	_____
j. Tumor or cancer	YES___	NO___	_____
k. High blood pressure	YES___	NO___	_____
l. Heart disease	YES___	NO___	_____
m. Bleeding disorder	YES___	NO___	_____

10. If applicable, are you pregnant? YES___ NO___

11. Please give the name, address and telephone number of your personal medical doctor (not your eye doctor):

    _____M.D.

    _____

    _____

    Telephone ( ) _____

_____

(Patient's Signature)