New Patient Medical History Form

Patient's Full Name: ____

Family Physician's Name: ____

Do you currently see an ophthalmologist, endocrinologist or rheumatologist? If so, please list their name(s).

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MEDICATIONS
Do you have any allergies to medications? If yes, please list:
List any medications you are currently taking (including oral contraceptives, aspirin, over the counter medications and vitamins):
List any ocular medications you are currently taking (including oral medications, eye drops and eye ointments):

MEDICAL HISTORY: Do you currently, or have you ever had any problems in the following areas?

		Y	N	List Condition			Y	N	List Condition
CARDIOVASCULAR	Heart Condition				**IMMUNOLOGIC**	Lyme Disease			
	High Blood Pressure					Sarcoidosis			
	CardiovascularDisease					HIV/AIDS			
	Stroke								
					INTEGUMENTARY	Skin			
CONSTITUTIONAL	Fever					Lupus			
	Weight Loss or Gain					Rosacea			
ENDOCRINE	Diabetes				**MUSCULOSKELETAL**	Rheumatoid Arthritis			
	Thyroid Condition					Muscle Pain			
	Crohn's Disease					Joint Pain			
	Gout					Down's Syndrome			
GASTROINTESTINAL	Hepatitis				**NEUROLOGICAL**	Headaches/Migraines			
	Acid Reflux					Brain Condition			
	Colitis					Vertigo			
GENITOURINARY	Kidney Disorder				**PSYCHIATRIC**	Depression			
	Bladder Disorder					Autism			
	Prostate Disorder								
	Ovarian Disorder				**RESPIRATORY**	Asthma			
	STDs					Chronic Bronchitis			
						Emphysema			
HEAD	Sinusitis					Lung Cancer			
	Hearing Loss								
	Meniere's Syndrome				**ALLERGY**	Seasonal			
						Environmental			
HEMATOLOGIC/	Anemia								
LYMPHATIC	Breast Cancer								
	Sickle Cell Disorder								

Are you pregnant? _______________ If so, how many weeks? ____________

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OCULAR HISTORY	Y	N	HOW LONG?
Cataracts			
Dry Eye			
Eye Infections			
Eye Turn			
Glaucoma			
Macular Degeneration			
Retinal Disease			
Other:			

FAMILY HISTORY – Any family history of the following?

SYSTEMIC HISTORY	Y	N	RELATIONSHIP	OCULAR HISTORY	Y	N	RELATIONSHIP
Arthritis				Blindness			
Cancer				Cataract			
Diabetes				Eye Turn			
Heart Disease				Glaucoma			
High Blood Pressure				Macular Degeneration			
Kidney Disease				Retinal Detachment/Disease			
Lupus							
Thyroid Disease							

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

____ ____________________________

Signature Date