Patient History Record

Have you ever been treated for any medical conditions?
(e.g., diabetes, high blood pressure, heart disease, etc.)

Yes____ No____ If yes, please explain____

Have you ever had any eye disease?
(e.g., glaucoma, cataract, etc.)

Yes____ No____ If yes, please explain____

Have you ever had eye surgery?

Yes____ No____ If yes, please explain____

Do you take any medications?

Yes____ No____ If yes, please explain____

Do you have any drug allergies?

Yes____ No____ If yes, please explain____

Medications

Medication	Dosage	How many times per day

1. ____

2. ____

3. ____

Family and Social History

Do you smoke? Yes____ No____ Packs per day____

Do you drink? Yes____ No____ Drinks per day____

Family Phiscian________________________________ Phone Number______________________________

Patient Name__________________________________ Date______/______/__________