**Personal Medical History**

**Name:** ________________________________________ **Family Physician:**___________________________

**Preferred Pharmacy:** ________________________ **Pharmacy Location:** ____________________________________

**How did you hear about us?:** Insurance ☐ Radio ☐ Facebook ☐ Internet ☐

Referring Doctor ☐ Who:_________________ ☐ Family/Friend ☐ Who:________________ Other ______________

## List all Allergies to Medication

(Or reactions)

No Known Drug Allergies ☐

| Name of Allergy | Reaction |
| --- | --- |
| | |
| | |
| | |
| | |

## List all medications you are now taking

(Include non-prescription drugs, vitamins, insulin, eye drops) or let us photocopy your list.

Medication list attached ☐

| Name of Medication | Purpose of Medication |
| --- | --- |
| | |
| | |
| | |
| | |
| | |

## List all major surgeries

(Including **eye surgeries**) you have had:

| Type of Surgery | Date | Type of Surgery | Date |
| --- | --- | --- | --- |
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |
| | | | |

***Please Continue Filling Out the Backside**

**Please check either yes or no for each question**

| Personal Medical History | Yes | | No | Please Explain Your Problem |
|---|---|---|---|---|
| Endocrine<br>(e.g. diabetes, thyroid) | | | | |
| Heart<br>(e.g. high blood pressure, phlebitis) | | | | |
| Neurological<br>(e.g. seizures, strokes, palsy, numbness) | | | | |
| Urological<br>(e.g. kidney, bladder, prostate) | | | | |
| Respiratory<br>(e.g. asthma, emphysema, oxygen use) | | | | |
| Gastrointestinal<br>(e.g. bleeding, ulcer, polyps) | | | | |
| Cancer<br>(e.g. all types of cancer & history) | | | | |
| Musculoskeletal<br>(e.g. deformities, muscles, arthritis) | | | | |
| Hematological<br>(e.g. anemia, easy bleeding) | | | | |
| Infections<br>(e.g.hepatitis, HIV/AIDS,recent influenza) | | | | |
| Skin<br>(e.g. rash, open sores) | | | | |
| Psychiatric<br>(e.g. depression, claustrophobia) | | | | |
| Immunologic<br>(e.g. hay fever, lupus) | | | | |
| Constitutional<br>(e.g. fevers, aches, etc.) | | | | |
| Other Problems<br>(e.g. recent hospitalization, injuries) | | | | |

**Family History: Please write in the relationship of the family member to you**

Blindness: ____________________________________ Color/ Night Vision Loss: ________________________________

Macular Degeneration: __________________________ Other Eye Problems: ________________________________

Diabetes: ____________________________________ Heart Disease: ______________________________________

Stroke:______________________________________ Cancer: ______________________________________________

Glaucoma: ___________________________________ Other: ___________________________________________

The **Main reason** I came in today is: ___________________________________________________________

**Social History:**

Current or Former Occupation _______________________________________________________ Retired ☐

Do you use tobacco? ______Yes ______ No ______Former ______Packs/day
Do you drink alcoholic beverages? ______Yes ______ No ______Times/wk ______Years ______Type
Do you use recreational drugs? ______Yes ______ No
Do you drive? ______Yes ______ No

**Patient Signature ______________________________________________________________________**