Today's Date_____Date Updated _____Date Updated _____

Strom Eye Center Comprehensive Medical History

Name : (Mr,Mrs,Miss) _____ **Date of Birth:** _____

Medical History:
Primary Care Physician: _____

EYE Medications and dosages you use: _____

_____

***List all MEDICATIONS, VITAMINS, AND SUPPLEMENTS WITH DOSAGES:**

_____

_____

_____

Are you allergic to any medications? No ☐ Yes ☐ Name of medication(s):_____
What was your allergic reaction? _____

Have you had any of the following:			Explanation of Problem
Previous Major Surgery	☐ yes	☐ no	_____
Heart Problems/Pacemaker	☐ yes	☐ no	_____
High Blood Pressure	☐ yes	☐ no	_____
Breathing Problems	☐ yes	☐ no	_____
Bowel Disease	☐ yes	☐ no	_____
Ulcers	☐ yes	☐ no	_____
Kidney Problems	☐ yes	☐ no	_____
Stroke	☐ yes	☐ no	_____
Seizures or Fainting	☐ yes	☐ no	_____
Arthritis	☐ yes	☐ no	_____
Diabetes	☐ yes	☐ no	_____
Thyroid Disease	☐ yes	☐ no	_____
Cancer	☐ yes	☐ no	_____
Other Major Illness	☐ yes	☐ no	_____
Keloid Scarring	☐ yes	☐ no	_____
Seasonal Allergies	☐ yes	☐ no	_____
Problems with anesthesia	☐ yes	☐ no	_____
Autoimmune Diseases	☐ yes	☐ no	_____
Claustrophobia/panic attacks	☐ yes	☐ no	_____
Other	☐ yes	☐ no	_____

(OVER)

Social History:

Do you smoke: ☐ yes ☐ no How Much? _____

Do you use alcohol: ☐ yes ☐ no How Much? _____

Your current or past Occupation: _____

Your Hobbies: _____

EYE HISTORY:

Approximate date of your last eye examination _____

What did the doctor say about your eyes? _____

Have you had any of the following?		Explanation of Problem
Serious Eye Injuries/infections	☐ yes ☐ no	_____
Cataract Surgery/Eye Surgery	☐ yes ☐ no	_____
Glaucoma	☐ yes ☐ no	_____
Cataracts	☐ yes ☐ no	_____
Macular Degeneration	☐ yes ☐ no	_____
Retina Detachment	☐ yes ☐ no	_____
Crossed Eyes or Lazy Eye	☐ yes ☐ no	_____
Dry Eye	☐ yes ☐ no	_____
Contact Lenses	☐ yes ☐ no	_____
Other Eye Diseases	☐ yes ☐ no	_____

FAMILY HISTORY:

Have any close blood relatives had any of the following problems?

		Which Relative?
Glaucoma	☐ yes ☐ no	_____
Macular Degeneration	☐ yes ☐ no	_____
Retina Detachment	☐ yes ☐ no	_____
Cataracts	☐ yes ☐ no	_____
Corneal Transplant	☐ yes ☐ no	_____
Blindness	☐ yes ☐ no	_____
Night Blindness	☐ yes ☐ no	_____
Crossed Eyes	☐ yes ☐ no	_____
Diabetes	☐ yes ☐ no	_____
Heart Disease	☐ yes ☐ no	_____
High Blood Pressure	☐ yes ☐ no	_____