MEDICAL HISTORY

Date: ________________

Name: ____ Age: ________ Sex: M F

Current Occupation: ____ Date Of Birth: ____/___/_____

Previous Occupational History: ____

OCULAR HISTORY:

Do you currently have or have you had:	YES	NO
1. Laser treatment to either eye?		
2. Surgery to either eye? (If Yes, please list)		
3. Injury to either eye? (If Yes, please list)		
4. Other serious medical eye disorder?		
5. Glaucoma?		
6. Macular Degeneration?		
7. Cataract?		

MEDICAL HISTORY:

Do you have or have you previously had: (Describe any "YES" on the last page if needed)	YES	NO
6. Heart Disease?		
7. Heart Attack?		
8. High blood pressue?		
9. A Stroke?		
10. Diabetes? If Yes, how long:		
11. Asthma or breathing problems?		
12. Liver or kidney disease?		
13. Hepatitis?		
14. Stomach / intestinal problems?		
15. Cancer? If Yes, Type:		
16. Bleeding Disorder, blood clots?		
17. Arthritis?		
18. Other Medical Problems? (Skin problems, etc.)		
19. Inherited disorder(s)?		
20. Medical problems resulting in hopsitalization?		

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Anne Miller, MD | David Smits, MD | Cullen Ryburn, MD | Brittney Statler, MD | Matthew Asano, MD
Arthur Korotkin, MD | Kristopher Hubbard, OD | Taylor Bowman, OD

SURGICAL HISTORY:	YES	NO
21. Any surgery other than eye(s)?		
22. Have you or someone in your family had a reaction to Anesthesia? If so, local or general?		

FAMILY HISTORY: Do you have a family history of:	YES	NO
23. Glaucoma?		
24. Macular Degeneration?		
25. Diabetes?		
26. Other eye problems?		
27. Lazy eye?		
28. Retinal Detachment?		
29: Non-ocular diseases?		

SOCIAL HISTORY:	YES	NO
30. Do you smoke?		
31. Marital status? (please circle) Married / Divorced / Single / Widowed		
32. Do you use alcohol?		

Who is your general medical practitioner? ____

Additional Comments?

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Patient Signature: ____