



PATIENT HISTORY RECORD

Name _____ Date _____

Birth Date _____ Sex _____ Age _____

Occupation / Hobbies / Interests _____

Referred by _____ Family Doctor _____

Please answer the following medical history questions:

1. Have you ever been treated for any medical conditions? (Heart disease, high blood pressure, diabetes, lung disease, stroke, etc.) Yes No If YES, please explain:

2. Have you ever had any eye disease, eye surgery or eye injury? Yes No If YES, what kind and when:

3. Have you **EVER** had **ANY** other surgery? Yes No If YES, what kind and when:

4. Do you take any eye medications? Yes No If YES, please list:

5. Do you take any other medications? Yes No If YES, please list:

6. Do you have any drug allergies? Yes No If YES, please list:

PLEASE SEE OTHER SIDE