# NEW PATIENT MEDICAL HISTORY

YOUR VISION OUR MISSION

*All info contained in this questionnaire is strictly confidential and will become part of your medical record.*

Name: _____ Today's Date: _____

Birth Date: _____

**ALLERGIES** ☐ NO ALLERGIES

| MEDICINAL ALLERGY | ALLERGIC REACTION |
|---|---|
| | |
| | |
| | |

| NON-MEDICINAL ALLERGY | ALLERGIC REACTION |
|---|---|
| *Such as latex, iodine, etc.* | |
| | |
| | |
| | |

**MEDICATIONS** ☐ NO MEDICATIONS ***Attach list if needed.***

| MEDICATIONS | DOSE | X DAY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Please circle any condition(s) for which you've been treated.**

| | |
|---|---|
| High Blood Pressure | Low Blood Pressure |
| Diabetes - Type 1 | Diabetes - Type 2 |
| Arthritis | Lupus |
| Leukemia | HIV |
| Kidney Stones | Renal Failure |
| Asthma\COPD | Bronchitis |
| Emphysema | Hashimotos |
| Graves Disease | Multiple Sclerosis |
| Stroke | Coronary Artery Disease |
| Heart Attack | Acid Reflux |
| Crohns Disease | Migraines |
| Cancer | Other _____ |

| **Please answer the following questions** | **Y/N** |
|---|---|
| Do you wear contacts? | |
| Are you interested in wearing contacts? | |
| **Do you have any of these eye problems?** | |
| Glaucoma | |
| Cataracts | |
| Trauma | |
| Crossed eyes | |
| Corneal disease | |
| Retinal detachment | |
| Macular Degeneration | |
| Are you pregnant or nursing? | |

**Pharmacy name:** _____

Pharmacy location: _____

List any previous EYE surgery: _____

List any other previous surgery: _____

**Indicate which blood relatives have the following:**
***(Mother, Father, Sister or Brother)***

| | |
|---|---|
| Crossed Eyes | |
| Arthritis | |
| Blindness | |
| Cancer | |
| Cataracts | |
| Diabetes | |
| Diabetic Retinopathy | |
| Glaucoma | |
| Heart Disease | |
| Hypertension | |
| Macular Degeneration | |
| Retinal Detachment | |
| Stroke | |

*I'm adopted* ☐

Do you drive? ☐ YES ☐ NO ☐ DAYTIME ONLY ☐ LOCAL ONLY

Have you had a flu vaccine this year? ☐ YES ☐ NO

Have you had 2 or more falls this year? ☐ YES ☐ NO

Have you had a pneumonia shot? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

If yes, how often? _____

Do you use tobacco? ☐ YES ☐ NO

If yes, indicate usage: _____

***Thank you!***