MEDICAL HISTORY

Your Name__________________________________Date of Birth__________________

What are the medical problems for which you take medicine?

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____

Please list the medication:

Medication Name	Dosage	Frequency

List Any Allergies to Medications.____

List Any Prior Surgeries.____

List Any Prior Eye Problems.____

~~ CONTINUED ON BACK ~~

Do you Smoke? ________**If so, how much?** ___________**If so, how many years?** ______

Do you Drink? _______**If so, how much?** ____________**If so, how many years?** ______

Do you use Drugs? _______**Which ones?** _______________**If so, how many years?** ______

Your Occupation ____________________**Marital Status** ________________________

Any problems with the following:	**Yes**	**No**	**If yes, can you describe?**
Heart, Blood Pressure, Blood Vessels			
Breathing Lungs			
Digestion, Intestines			
Kidneys, Bladder, Prostate			
OB/GYN			
Glands, Hormones, Liver, Thyroid			
Hearing, Smell, Throat			
Muscles, Joints, Arthritis, Bones			
Skin, Breasts			
Headache, Seizure, Stroke			
Blood, Anemia			
Immune System, Allergies			

Are there any medical problems which run in your family?

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Name and Phone Number of PCP (Primary Care Physician)

________________________________ _________________________________

Name and Phone Number of Pharmacy

________________________________ _________________________________

Patient Signature_________________________________**Date**_______________________