Medical History Update

Name:____ Date:_____________________

Primary care provider:_____________________________________

Many medical conditions and medications can affect the eyes, so it is important that we are aware of any changes in your medical history. We appreciate you taking the time to answer the questions below.

Are you currently being treated for any of the following (please check all that apply):

___High blood pressure ___Diabetes ___Breathing problems
___Heart disease ___Thyroid disorder ___Autoimmune disease
___Cancer _____________ ___Other_______________

Do you currently have any symptoms listed below (please check all that apply):

___Environmental allergies
___Chest pain/Irregular heartbeat
___Fever/unexplained weight gain or loss
___Dry mouth/chronic congestion
___Blood sugar variations/excessive urination or thirst
___Chronic nausea/intestinal disorders/abdominal pain
___Urinary difficulties
___Unusual bleeding, easy bruising
___Autoimmune disorder/infectious disease
___Skin lesions/masses/changes in pigmentation
___Unexplained muscle or joint pain
___Stroke/seizure/numbness/tingling/weakness
___Anxiety/depression/mood swings
___Shortness of breath/chronic cough

Current height:__________________ Current weight:_________________

Medications (including Rx and non-Rx):	Dosage:	How often:
________________________________	________________	______________________
________________________________	________________	______________________
________________________________	________________	______________________
________________________________	________________	______________________
________________________________	________________	______________________
________________________________	________________	______________________

Have you had any recent surgeries or other changes in your medical health? _____ No ____Yes

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