NORTH DAKOTA EYE CLINIC MEDICAL HISTORY

Name: _____

Date of Birth: ____/____/____ **Age:** _____

Primary Care Physician's Name: _____

Were you referred by an Optometrist? No____ Yes (please name) _____

Please list current eye diseases or disorders you have:

_____

_____

Please list eye surgeries or eye injuries you have had:

_____

_____

Please list any other surgeries or injuries you have had: (i.e. tonsillectomy, knee surgery, etc.)

_____

_____

Please list all medications you are currently taking: ____I am not taking any medications.

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any medications? No____ Yes (please list):_____

_____

Please check any of the following that YOU have:

____High Blood Pressure
____High Cholesterol
____Diabetes
____Lung Problems
____Heart Problems
____Thyroid Problems
____Stroke
____Rheumatoid Arthritis
____Other: _____

Please check if you have a FAMILY HISTORY of the following:

____Glaucoma ____Macular Degeneration ____Diabetes ____Other: _____

Please tell us about YOUR social history:

____Tobacco – amount: _____
____Alcohol – amount: _____ Occupation: _____

I acknowledge that I have read and completed the North Dakota Eye Clinic Medical History form and that the above information is accurate and complete to the best of my knowledge.

_____

Patient Signature Date