LaFollette eye clinic

the eyewear gallery

# Confidential Patient Medical History

**Name:**_____ **Date of Birth:**_____**Date:**_____

**Eye Health:** Please circle any eye problems you have or have had in the past:

| | | | |
|---|---|---|---|
| **Glaucoma** | **Cataracts** | **Macular Disease** | **Flashes/floaters** |
| **Injury** | **Retinal problems** | **Lazy eye/eye turn** | **Itch/burn/water/gritty** |

**Other:**_____

**Medical Health:** Please circle any medical problems you have or have had in the past:

| | | | |
|---|---|---|---|
| **Diabetes** | **Headaches** | **Arthritis** | **High Blood Pressure** |
| **Fainting** | **Slow Heart Rate** | **Allergies/hay fever** | **Pacemaker** |
| **Thyroid Disease** | **Cancer** | **Breathing Problems** | **AIDS/HIV/Hepatitis** |

**Other:**_____

| | | |
|---|---|---|
| **Do you smoke?** | **Yes** | **No** |
| **Do you drink alcohol?** | **Yes** | **No** |
| **Are you pregnant or nursing?** | **Yes** | **No** |

**Please list any allergies to medicines:**

_____

_____

**Please list all current medicines with dosages:**

_____

_____

_____

_____

_____

_____

_____