Patient Name: _____

DOB: _____

Great River Eye Clinic

MEDICAL HISTORY

Date: _____

Family Doctor: _____ **Optometrist:** _____

Do You?	Yes	No		Yes	No
Use Alcohol:	☐	☐	Use Recreational Drugs	☐	☐
Use Tobacco:	☐	☐	Ever Exposed to Second Hand Smoke	☐	☐

Occupation: _____ Hobbies: _____

Eye Diseases: Which do you currently have or have had in the past?

	Yes	No		Yes	No		Yes	No
Cataracts	☐	☐	Glaucoma	☐	☐	Macular Degeneration	☐	☐
Crossed Eyes	☐	☐	Lazy Eye	☐	☐	Floaters/ Light Flashes	☐	☐
Detached Retina	☐	☐	Other _____					

Family Eye History: Have your Parents, Grandparents, Brothers or Sisters had any of the following?

	Yes	No		Yes	No		Yes	No
Blindness	☐	☐	Detached Retina	☐	☐	Lazy/ Crossed Eye	☐	☐
Cataracts	☐	☐	Glaucoma	☐	☐	Macular Degeneration	☐	☐

Current Health Conditions: Do you have any of the following?

	Yes	No		Yes	No
Arthritis	☐	☐	Lupus	☐	☐
Asthma or Emphysema	☐	☐	Mental Health Problems	☐	☐
Blood or Bleeding Disorders	☐	☐	Other Heart Disease	☐	☐
Cancer	☐	☐	Reaction to Anesthetics	☐	☐
Diabetes How Long? _____	☐	☐	Seasonal Allergies	☐	☐
Ear/ Mouth/ Nose/ Throat Disease	☐	☐	Seizure Disorder	☐	☐
Headaches Other than occasional	☐	☐	Sinus Disease	☐	☐
Hepatitis A, B, or C	☐	☐	Skin Conditions	☐	☐
High Blood Pressure	☐	☐	Stomach/ Intestinal Problems	☐	☐
High Cholesterol	☐	☐	Stroke/ Neurological Disease	☐	☐
HIV/ AIDS	☐	☐	TB or other Lung Disease	☐	☐
Irregular Heart Beat	☐	☐	Thyroid Disease	☐	☐
Kidney/ Urinary/ Genital Disease	☐	☐	Other _____		

Allergies List ALL known allergies, include medication.	**Previous Surgeries** List ALL non-ocular (non-eye) surgeries.	**Eye History** List eye related injuries & surgeries with dates.