CALIFORNIA EYE CLINIC
PATIENT MEDICAL HISTORY

PATIENT NAME: _____ **DOB:** _____ **DATE:** _____

PRIMARY CARE PHYSICIAN: _____

ALLERGIES TO MEDICATIONS: _____

LIST OF MEDICATION:
Medication Name/Strength/Direction

FAMILY HISTORY:

	Yes	No
Heart Disease:	☐	☐
Family Member:		
Diabetes:	☐	☐
Family Member:		
Glacoma:	☐	☐
Family Member:		
Cataracts:	☐	☐
Family Member:		

PATIENT HISTORY:

Past Eye Problems:		
Previous Eye Surgery:	☐	☐
Previous Eye Trauma:	☐	☐
Flu shot this season:	☐	☐
Do you smoke:	☐	☐
Have you ever smoked:	☐	☐
Pnemoccocal Vacine within the last 10 years:	☐	☐

PATIENT HISTORY CONTINUED:

	Yes	No
Do you drink alcohol?	☐	☐
Daily _____ Weekly _____ Socially _____		
Arthritis:	☐	☐
Diabetes:	☐	☐
Heart Trouble:	☐	☐
High blood pressure:	☐	☐
Stroke:	☐	☐
Epilepsy:	☐	☐
Asthma/Emphysema:	☐	☐
Cancer (except skin cancer):	☐	☐
Hepatitis:	☐	☐
HIV:	☐	☐
Tuberculosis:	☐	☐

OTHER MEDICAL PROBLEMS:

FOR OFFICE USE ONLY

Medical Update:

Date: Initial:

Date: Initial:

Date: Initial:

Date: Initial:

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