Patient Medical History Form
Hometown Ophthalmology

Name _____

Who is your primary care doctor? _____

List any specialist doctors that you see: _____

Past Medical History: Circle any of the conditions that you have:

Diabetes	High Blood Pressure	Blood clots	Lung Disease
Heart Disease	History of Stroke	Bad reaction to anesthesia	
Cancer	Bladder or Prostate issues	Headaches	Kidney Disease
Autoimmune disease	Seasonal Allergies	Thyroid Disease	

Other:

Past eye history: Circle any that of these that apply to you:

Eye surgery Laser Eye Surgery Treated with eye drops Treated with Eye Injections

Other eye condition: _____

List any surgeries you have had (eye or body):

_____

_____

Do you have any drug allergies? _____

Do you smoke? YES NO Do you drink alcohol daily? YES NO

Please list any medications that you take: (OK to give a list instead)

Have any of your FAMILY MEMBERS been diagnosed with any of the following? (circle if yes)

Glaucoma Macular Degeneration Retinal Detachment Blindness

Other eye disease: _____