Medical History Form

Name:______________________________ Date: ______________________________

Referred by:______________________________ Primary care M.D.:______________________________

Occupation:______________________________ Height: ____________ Weight: ____________

DOB: ______/______/______ Age: ______________ Dominant hand: ☐ Right ☐ Left ☐ Ambidextrous

Reason for this visit: ____

Other medical problems:	Past surgeries:

Medications and dose schedule (attach a separate sheet if needed):

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Drug allergies: ☐ None

1. ______________________
2. ______________________
3. ______________________

Your preferred pharmacy: ____

Use of tobacco: ☐ Never ☐ Previously — Year quit:________ Current packs per day: ______________

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Recreational drugs: ☐ Never ☐ Yes Type/frequency: ______________________________

Review of systems: Do you currently have any of the following problems?

	No	Yes	If yes, please explain:
Neurological problems (e.g., headaches, stroke, memory problems)	☐	☐	
Eye disease (e.g., glaucoma, cataracts, wandering or lazy eye)	☐	☐	
Chronic fever, unexpected weight loss, fatigue	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	☐	☐	
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea)	☐	☐	
Urinary problems (e.g., pain, incontinence, blood in urine)	☐	☐	
Endocrine problems (e.g., diabetes, thyroid disease, menstrual problems)	☐	☐	
Psychiatric problems (e.g., depression, anxiety, anger problems)	☐	☐	
Hematology problems (e.g., HIV, Hepatitis C)	☐	☐	

Family medical history: Any immediate family members with a history of either eye or neurological disease?

☐ No ☐ Yes If yes, please explain: ____

____

M.D. initials: ______________________

We do not discriminate on the basis of race, color, national origin, sex, age, or disability in our health programs and activities.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中 文翻譯服務，請致電 888-311-9127 (Swedish Edmonds 888-311-9178) (TTY: 711)

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