Bossier Family eye care

Medical History Record

Currently wearing:
☐ Glasses ☐ Contacts

Patient Name: _____ Date: _____ Referred by: _____

First & Last Name of primary physician: _____ Last Eye Exam: _____

Pharmacy Name and Street Address: _____

Personal Medical Information: Have you been diagnosed with any of the following? If YES, please check box.

☐ None
☐ ADHD/ADD
☐ Anxiety
☐ Asthma
☐ COPD
☐ Arthritis
Type:_____
☐ Migraines

☐ Coronary Artery
☐ Depression
☐ Enlarged Prostate
☐ GERD
☐ Hearing Loss
☐ Cancer
Type:_____
☐ Other: _____

☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Hyperthyroidism
☐ Diabetes
Type:_____

☐ Hypothyroidism
☐ Irregular Heartbeat
☐ Radiation Treatment
☐ Renal Disease
☐ Seizures
☐ Sleep Apnea
☐ Stroke

Has a Doctor diagnosed you with any **eye conditions**? ☐ Yes ☐ No
If yes, please list: _____

Have you ever had any **eye surgeries** or **injuries**? ☐ Yes ☐ No
If yes, please list : _____

Have you ever had any surgeries other than eye surgery? ☐ Yes ☐ No
If yes, please list (type & year): _____

List all medications, as well as dosage amount and frequency. (Including: OTC / Vitamins / Eye Drops)

Name of medication	Dosage	Frequency

Do you have allergies to any medications? ☐ Yes ☐ No
If yes, please list _____
Do you have seasonal or outdoor allergies? ☐ Yes ☐ No

Please check Yes or No:

Do you drink alcohol? ☐ Yes ☐ No How many drinks a day: _____
Do you use any recreational drugs? ☐ Yes ☐ No Do you use chew/snuff: _____
Do you smoke? ☐ Yes ☐ No Year started / how many packs per day: _____
Are you a Previous smoker? ☐ Yes ☐ No Year started & year quit: _____

Please, check box of any of the following that apply to family history: (List family member, Up to patient's grandparents)

☐ None
☐ Blindness: _____
☐ Cancer (+Type): _____
☐ Diabetes (+Type):_____
☐ Retinal Detachment:_____

☐ Glaucoma: _____
☐ Heart disease/failure: _____
☐ High Blood Pressure: _____
☐ Macular Degen: _____
☐ Other: _____