CHEYENNE EYE CLINIC & SURGERY CENTER

MEDICAL HISTORY

Date: _____

Name: _____ Age: _____ Sex: M F

Current Occupation: _____ Date Of Birth: _____ /_____ /_____

Previous Occupational History: _____

OCULAR HISTORY:

Do you currently have or have you had:	**YES**	**NO**
1. Laser treatment to either eye?		
2. Surgery to either eye? *(If Yes, please list)*		
3. Injury to either eye? *(If Yes, please list)*		
4. Other serious medical eye disorder?		
5. Glaucoma or Cataract?		

MEDICAL HISTORY:

Do you have or have you previously had: *(Describe any "YES" on the last page if needed.)*	**YES**	**NO**
6. Heart Disease?		
7. Heart Attack?		
8. High blood pressure?		
9. A Stroke?		
10. Diabetes? If Yes, how long:		
11. Asthma or breathing problems?		
12. Liver or kidney disease?		
13. Hepatitis?		
14. Stomach / intestinal problems?		
15. Cancer? If Yes, Type:		
16. Bleeding Disorder, blood clots?		
17. Arthritis?		
18. Other medical problems? (Skin problems, etc.)		
19. Inherited disorder?		
20. Medical problems resulting in hospitalization?		

SURGERY:	**YES**	**NO**
21. Any surgery other than eyes? *(If Yes, please list below)*		
22. Have you or someone in your family had a reaction to Anesthesia? If so local or general?		

MEDICINES:

Do you currently take: *(Please list on last page)*	**YES**	**NO**
23. Eye drops?		
24. Aspirin / aspirin related compounds?		
25. Prescription medicines?		
26. Other medicines? (Vitamins, etc.)		

ALLERGIES:	**YES**	**NO**
27. Sulfa?		
28. Eye drops?		
29. Other medicines? *(If Yes, please list)*		
30. Any reaction to shots form dentist?		

FAMILY HISTORY: Do you have a family history of:	**YES**	**NO**
31. Glaucoma?		
32. Macular degeneration?		
33. Diabetes?		
34. Other eye problems?		
35. Lazy eye?		
36. Retinal Detachment?		
37. Non-ocular diseases? (If Yes, please list)		

SOCIAL HISTORY:	**YES**	**NO**
38. Do you smoke?		
39. Marital status? *(Please circle)* Married / Divorced / Single / Widowed		
40. Do you use alcohol?		

Who is your general medical physician? _____

MEDICATIONS

	Medication	**Dosage**
Eye drops:	_____	_____
Prescription Medicine: **Please provide a list of medications; if there is not enough room provided on this sheet*	_____	_____
	_____	_____
	_____	_____
	_____	_____
Other Medicines (Vitamins, etc.):	_____	_____
	_____	_____

Additional Comments:

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Reviewed by Technician _____ Date: _____

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