

# Patient Medical History Form

Sticker Here

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

1) Please check if any of the following medical conditions which apply to you:  
(These are specific conditions which more information may be needed)

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|---|---|
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Claustrophobia                         |
| <input type="checkbox"/> Thyroid disorder                                       | <input type="checkbox"/> Allergies / Hayfever                   |
| <input type="checkbox"/> Parkinson's  | <input type="checkbox"/> Optic nerve drusen                     |
| <input type="checkbox"/> Multiple Sclerosis                                     | <input type="checkbox"/> Herpes simplex or Herpes zoster (eyes) |
| <input type="checkbox"/> Fibromyalgia   | <input type="checkbox"/> Dry eyes                               |
| <input type="checkbox"/> Migraines  | <input type="checkbox"/> Corneal disease or abnormality         |
| <input type="checkbox"/> Chrohn's disease                                       | <input type="checkbox"/> Eye disease                            |
| <input type="checkbox"/> Cancer (pls specify) _____                             | <input type="checkbox"/> High blood pressure                    |
| <input type="checkbox"/> Depression, if so, please explain: _____               |   |
| <input type="checkbox"/> Any other medical issues we should be aware of?: _____ |   |

2) Please list **all your medications**. This includes your doctor's prescribed, and/or over-the-counter medications, (such as, vitamins and herbal supplements). **Please** include the name of the medication, dosage (mg, mcg, etc), frequency taken (once a day, as needed, etc.), route (by mouth), and the reason why you take it.

**None** (please check box if you are not taking any prescribed medications or over-the-counter medications.)

Medication/Supplement Name	Dosage	Frequency Taken	Route	Reason Taken

3) Please list any allergies or sensitivities to medications, foods, or materials:

**None**

Allergy/Sensitivity	Type of Reaction

(Please continue on other side)

4) **If you check any of the following, please call us at 262-789-9029 prior to your appointment.**

- If you are pregnant or nursing
- If you have autoimmune diseases
- If you have collagen vascular disease
- If have an immunodeficiency disease
- If you've had herpetic eye ulcers in the past one year
- If you've been diagnosed with keratoconus or family history of keratoconus
- If you have taken Cordarone or Accutane in the past 6 months

5) Please list all previous major surgeries and hospitalizations (include dates or approximate dates):

**None**

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Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff's Signature: \_\_\_\_\_

Surgeon's Signature: \_\_\_\_\_

For office use only:

<input type="checkbox"/> No changes	<input type="checkbox"/> Changes as above _____	<input type="checkbox"/> No changes	<input type="checkbox"/> Changes as above _____
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