

# Patient Medical History Form

Sticker Here

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

- 1) Please list **all your medications**. This includes your doctor's prescriptions, non-prescriptions, vitamins and herbal supplements. **\*YOU MUST** include the name of the medication, dosage (mg, mcg, etc), frequency taken (once a day, as needed, etc.), and the reason why you take it.

Medication/Supplement Name	Dosage	Frequency Taken	Route	Reason Taken
Ex: One-a-Day Vitamins	----	Once daily	By mouth	Fatigue

- 2) Please list any allergies or sensitivities to medications, foods, or materials: (Ex: Latex – Hives)

Allergy/Sensitivity	Type of Reaction

- 3) Please list **all conditions (including eye conditions)** that you are currently under treatment for by Doctors: (Ex: Migraines, dry eyes)

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- 4) Please list all previous major surgeries and hospitalizations (include dates or approximate dates): (Ex: Heart bypass – 06/21/99)

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(Please continue on other side)

5) Please check if any of the following medical conditions, eye problems, or medications 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"/> Migraine Medication – Imitrex, Amerge  | <input type="checkbox"/> Corneal disease or abnormality          |
| <input type="checkbox"/> Chrohn's Disease   | <input type="checkbox"/> Eye disease such as cataracts, glaucoma |
| <input type="checkbox"/> Prostate Medication – Flomax, Hytrin, Cardura, Uraxatrol, or Supplement Saw Palmetto |  |
| <input type="checkbox"/> Blood Thinners – Coumadin, Plavix, Warfarin, or Asprin                               |  |
| <input type="checkbox"/> Depression, if so, please explain: _____   |  |

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

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

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

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

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

**For office use:**

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