Medical History

Fritch Eye Care Medical Center

Date: _____

Name: _____ Age: _____ Sex: M F Height: _____

Occupation: _____ Hobbies: _____ Weight: _____

Smoker: Y N Quit When: _____ How much: _____ Alcohol: Y N How much: _____

Allergies to Medications or Painkillers: N Y (List): _____

_____

Medications: (Both regular and occasional use, prescription and non-prescription)

_____

_____

_____

_____

Under an MD's care? Y N Name: _____ Phone: _____

Name: _____ Phone: _____

Have you ever had or have any of the following:

Y	N	Arthritis	Y	N	High Cholesterol
Y	N	Asthma	Y	N	HIV Positive (Aids)
Y	N	Blood Disorder	Y	N	Kidney / Urinary Problems
Y	N	Cancer	Y	N	Lung / Respiratory
Y	N	Diabetes	Y	N	Neurological Problems
Y	N	Dizzy Spells	Y	N	Parkinson's
Y	N	Excessive Bleeding	Y	N	Seizure / Epilepsy
Y	N	Head / Neck Injury	Y	N	Skin Problems
Y	N	Heart / Circulation Problem	Y	N	Stroke
Y	N	Hepatitis Type A B C D E	Y	N	Tuberculosis
Y	N	High Blood Pressure			

Others: _____

_____

Pregnant? Y N Nursing? Y N Previous Surgery? N Y (list)

Hospitalized for other than surgery? Y N _____

Any history of substance abuse? Y N _____

_____

Family member with any of the following:

Y	N	Diabetes	Who: _____
Y	N	Hypertension	Who: _____
Y	N	Arthritis	Who: _____
Y	N	Neurological	Who: _____
Y	N	Tuberculosis	Who: _____

Confirmed / Obtained Orally Yes No Date: _____