MEDICAL HISTORY

Patient Name:	Date:
Primary Care Physician:	Referring Provider:

PLEASE CIRCLE ALL THAT APPLY TO YOU AND YOUR IMMEDIATE FAMILY

	SELF	FAMILY		SELF	FAMILY
Anemia	Y / N	Y / N	High Blood Pressure/Hypertension	Y / N	Y / N
Autoimmune Disorders	Y / N	Y / N	Heart Disease	Y / N	Y / N
Asthma	Y / N	Y / N	Herpes (cold sores/ shingles)	Y / N	Y / N
Arthritis	Y / N	Y / N	Hepatitis A,B or C	Y / N	Y / N
Atopic Syndrome	Y / N	Y / N	HIV	Y / N	Y / N
Bleeding Disorders	Y / N	Y / N	Irregular Heart Beats	Y / N	Y / N
Bronchitis	Y / N	Y / N	Keloid Scar Formation Hx	Y / N	Y / N
Clotting Disorders (Emboli)	Y / N	Y / N	Kidney Disease	Y / N	Y / N
Cancer	Y / N	Y / N	MRSA Infection	Y / N	Y / N
Chronic Cough	Y / N	Y / N	Pneumonia	Y / N	Y / N
Congestive Heart Failure	Y / N	Y / N	Pacemaker	Y / N	Y / N
COPD	Y / N	Y / N	Systemic Connective Tissue Disease	Y / N	Y / N
Diabetes	Y / N	Y / N	Sickle Cell	Y / N	Y / N
Emphysema	Y / N	Y / N	Stroke	Y / N	Y / N
Fibromyalgia	Y / N	Y / N	Seizures	Y / N	Y / N
Heart Murmur	Y / N	Y / N	Sleep Apnea	Y / N	Y / N
Heart Attack	Y / N	Y / N	Thyroid	Y / N	Y / N

EYE HISTORY

Lazy Eye	Y / N	Eye Allergies	Y / N	Cataracts	Y / N
Double Vision	Y / N	Dry Eye Problems	Y / N	Lasik, RK or PRK	Y / N
Floaters/ Spots	Y / N	Diabetic Eye Problems	Y / N	Glasses	Y / N
Retinal Detachment	Y / N	Eye Injury	Y / N	Contact Lens Wearer: ***HARD OR SOFT***	Y / N
Eye Disease		Glaucoma	Y / N	Self / Parent / Grandparent	
		Macular Degeneration	Y / N	Self / Parent / Grandparent	

MEDICATION HISTORY

List all medications you are currently taking, including over the counter meds and supplements

DRUG NAME	STRENGTH	HOW OFTEN USED	DRUG NAME	STRENGTH	HOW OFTEN USED

- Have you ever taken any Alpha Blocker medications such as:
  Flomax (tamsulosin), Hytrin (terazosin), Cardura (doxazosin), Uroxatral (alfuzosin)? **YES** **NO**
- Have you or a blood relative ever had a problem with anesthesia? **YES** **NO**
- Have you had any problems with dental injections? **YES** **NO**
- Have you recently taken Accutane, Cardarone, or migraine medications? **YES** **NO**
- Are you taking a Beta Blocker at this time? **YES** **NO**

SURGERY HISTORY

Please list previous surgeries you have had and when

Type of Surgery	Date	Type of Surgery	Date

ALLERGY HISTORY

Please list all allergies you have to medications, foods, and soaps

Name of Drug, Food or Soap	Type of reaction (rash, hives, swelling, etc.)

- Are you sensitive to topical Iodine? **YES NO**
- Are you sensitive to any type of tape? **YES NO**
- Do you have an allergy or sensitivity to Latex? **YES NO**

SOCIAL HISTORY

Do you Smoke? **NOW or PAST**	YES / NO	How many packs per day?	For how many years?
Alcohol use?	YES / NO	How often & How Much?	For how many years?
Recreational Drug Use?	YES / NO	Name of Drug(s):	For how many years?

Print Name

Signature of patient or guardian

Date