ARKANSAS EYE SITE

Patient Name _____

Patient Medical History Form

Please complete the following form as thoroughly as possible.
The information in this history form is confidential and critical to your visual and health evaluation.

Please List Current Medications:
(Including vitamins, birth control and over the counter medications)

- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____

Please List Eye Drops Or Eye Medications you use:

- _____ • _____
- _____ • _____

Are you ALLERGIC to any medications? Please list:

- _____ • _____
- _____ • _____

Do you use tobacco products? ❑ Yes ❑ No
Former tobacco user? ❑ Yes ❑ No
Do you drink alcohol? ❑ Yes ❑ No

Have you ever had an eye-related surgery?
❑ Yes ❑ No

If yes, please specify:
• _____

Please List All Surgical History:

- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____
- _____ • _____

Have you ever experienced, been diagnosed, or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of Light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Watering
❑ Uncomfortable Glasses
❑ Eye Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Other Eye Disorders: _____

Have you ever been diagnosed with the following?

❑ Acid Reflux
❑ Allergies/Sinus
❑ Alzheimer's/Dementia
❑ Arthritis
❑ Asthma
❑ Blood/Lymph
❑ Cancer
❑ Cholesterol
❑ Crohn's/IBS
❑ COPD/Emphysema
❑ Depression/Anxiety
❑ Diabetes
❑ Eczema/Rashes
❑ Epilepsy
❑ Fibromyalgia
❑ Heart Attack
❑ Heart Disease
❑ High Blood Pressure
❑ Lupus
❑ MS
❑ Parkinson's
❑ Stroke
❑ Thyroid
❑ Other: _____

Do you have a FAMILY history of any of the following?
Check all that apply and indicate relationship.
(Deceased and Living)

❑ Cataracts _____
❑ Glaucoma _____
❑ Macular Degeneration _____
❑ Retinal Problems _____
❑ Corneal Problems _____
❑ Lazy Eye _____
❑ Diabetes _____
❑ High Blood Pressure _____
❑ Heart Disease _____
❑ Cancer _____
❑ Other: _____
❑ Other: _____