

MEDICAL HISTORY / PSFH (Past Social Family History)

CHART# _____

Name: _____ Date of Birth: _____

Address: _____ Male / Female

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name & Location (Street Name, City) _____

MEDICAL CONDITIONS: (PLEASE CIRCLE IF YES): Are you Diabetic? Do you have Heart Disease?
Have you been diagnosed with Cancer? Have you ever been diagnosed with: Diabetic Retinopathy,
Glaucoma, Macular Degeneration, Corneal or Retinal Problems, Cataracts.

Other Medical Conditions _____

EYE HISTORY: Have you ever had cataract surgery?, LASIK surgery? List All Other Eye or Eyelid
Surgery you have had: _____

LIST ANY OTHER SURGERY YOU HAVE HAD:

LIST ALL DRUG ALLERGIES

FAMILY HISTORY – Do any members of your immediate family (blood relatives) have a history of:
Macular Degeneration - Yes No - Relationship? _____
Glaucoma - Yes No - Relationship? _____
Diabetes - Yes No - Relationship? _____

FAMILY MEDICAL HISTORY CONTINUED:
Is mother deceased? Y / N If yes- cause of death? _____ Age at death? _____
Is father deceased? Y / N If yes- cause of death? _____ Age at death? _____

SOCIAL HISTORY:
(Circle): Student Homemaker Employed Retired **(Circle):** Single Married Separated Divorced Widowed
Do you use Tobacco? Yes / No Cigarettes / Smokeless _____
Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other _____
Substance Abuse? Yes / No Rarely Daily Weekly _____

(PLEASE COMPLETE PAGE 2 ON THE BACK)

