GENERAL MEDICAL HISTORY

| atient Name: Date of | | | | | Birth: Occupation: | | | | | |
|----------------------|--|---|------|--------------------------------------|---------------------------------|--|----------------------|---------|--------------------|--|
| | | | | City: | | | Phone: | | | |
| | ıs - List | any medicatic ————————— Medica | | larly including over-the-counter and | | | | | | |
| Date | | Iviedica | IUON | Dose | Freq. | | Oral / Injectable | | ALLERGIES | |
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| | | | - | | | | | | | |
| Surge | Surgeon Date Ophthalmic Surgeries (eye | | | | Ocular I | Diagnos | sis DX (eye) Weight: | | | |
| | | | | | | | | | Height: | |
| | | | | | | | | | Tobacco: yes or no | |
| | | | | | | | ···· | Amount | | |
| | | | | | | ······ | | Counsel | ed: yes or no | |
| YES | NO | | | | YES | NO | | | | |
| | | Pacemake | | | | ney Disease | | | | |
| | | Defibrillate | | | Tuberculo | | | | | |
| | | High Blood | | | Migraines | | | | | |
| | | Blood Thir | | | = | Depression, Anxiety or other Disorder Carotid Artery Disease | | | | |
| | | Diabetes Stroke | | | | Jarotid Artery Disease Head or Spinal Injuries | | | | |
| | | Asthma / (| | | Seizures, Convulsions, Fainting | | | | | |
| | ٥ | HIV | | | Temporal Arteritis | | | | | |
| ٥ | ā | Heart Dise | | | Cancer | | | | | |
| ā | | Artificial J | | | Other: | | | | | |
| - | _ | Date & typ | | | Family history of eye problems: | | | | | |
| | MAG | *************************************** | | | | | | | | |
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| Technicia | n signa | iture: | | | | | Date: | | | |