MONNETT EYE & SURGERY CENTER MEDICAL HISTORY

Name_____ Account #_____

Date ___/___/___ Height_____ Weight_____lbs. Age_____

Family Physician_____

Allergies (and type of reaction)_____

_____

_____

MEDICATION LIST ... PLEAST LIST ALL DOSAGES & TIMES PER DAY

DATE	MEDICATION	RX/?	WHEN	DATE	MEDICATION	RX/?	WHEN	DATE	MEDICATION	RX/?	WHE
		mg				mg				mg	
		mg				mg				mg	
		mg				mg				mg	
		mg				mg				mg	
		mg				mg				mg	
		mg				mg				mg	
		mg				mg				mg	
		mg				mg				mg	
		mg				mg				mg	
		mg				mg				mg	

CHANGE CHANGE CHANGE

DO YOU NOW HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

*******Please answer Yes or No for all questions*******

	Yes	No		Yes	No		Yes	No
HIGH BLOOD PRESSURE	☐	☐	CHRONIC COUGH	☐	☐	BLACKOUTS	☐	☐
LOW BLOOD PRESSURE	☐	☐	EXPOSURE TO TUBERCULOSIS	☐	☐	BLOOD DISORDERS	☐	☐
HEART ATTACK __/__/__	☐	☐	ASTHMA, WHEEZING	☐	☐	RHEUMATIC FEVER	☐	☐
HEART MURMUR	☐	☐	ABNORMAL CHEST X-RAY	☐	☐	MENINGITIS, POLIO	☐	☐
HEART PALPITATIONS	☐	☐	CANCER	☐	☐	ARTHRITIS	☐	☐
IRREGULAR HEART BEAT	☐	☐	STROKE / DIZZINESS	☐	☐	BRUISE OR BLEED EASILY	☐	☐
PACEMAKER	☐	☐	ULCER / HIATAL HERNIA	☐	☐	BLOOD CLOTS	☐	☐
CHEST PAIN / ANGINA	☐	☐	THYROID DISEASE	☐	☐	ANEMIA	☐	☐
CONGESTIVE HEART FAILURE	☐	☐	NERVOUS DISORDER	☐	☐	SICKLE CELL ANEMIA	☐	☐
DIABETES / HYPOGLYCEMIA	☐	☐	EPILEPSY / SEIZURES	☐	☐	BACK PROBLEMS	☐	☐
BRONCHITIS / EMPHYSEMA	☐	☐	KIDNEY PROBLEMS	☐	☐	BLINDNESS / DEAFNESS	☐	☐
PNEUMONIA / LUNG PROBLEMS	☐	☐	HEPATITIS, LIVER PROBLEMS	☐	☐	HEADACHES	☐	☐
SHORTNESS OF BREATH	☐	☐	INTESTINAL DISEASE	☐	☐	AIDS	☐	☐
RECENT COUGH / COLD	☐	☐	PSYCHIATRIC DISORDER	☐	☐	IMMUNE DEFICIENCY	☐	☐

Other, not mentioned conditions Yes ☐ No ☐ _____

List all Surgeries, and the date ~ List Hospitalizations, reasons and dates

_____

_____

_____

_____

Has anyone in your immediate family had any of the following conditions? If so, Whom _____

	Yes	No		Yes	No		Yes	No
HEART DISEASE	☐	☐	CATARACTS	☐	☐	GLAUCOMA	☐	☐
CANCER	☐	☐	BLOOD PRESSURE	☐	☐	TB	☐	☐
DIABETES	☐	☐	CROSSED EYES	☐	☐	MACULAR DEGENERATION	☐	☐
OTHER EYE PROBLEMS	☐	☐						