

Medical History Record

D. A. Brodmann OD

Height _____ Weight _____ Blood Pressure _____ / _____

Personal Medical Information: Do you have problems with any of these systems? If yes please check .

- | | | |
|---|--|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous System | <input type="checkbox"/> Mental |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Endocrine (Glands) |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Blood/Lymph |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | <input type="checkbox"/> Allergic/Immunologic |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Surgeries | |

If you checked surgeries, what procedure and when: _____

Any allergic reactions to medications or other substances? Yes No

If yes, please list _____

Name of general physician _____

Please check yes or no.

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much? _____

Do you take medications? Yes No Please list names and how often _____

Do you use other substances? Yes No

Do you have any family history of any of the following? If yes, please check box.

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Cataracts |

Please explain any boxes you have checked: _____

Have you been experiencing any of the following? Please check all that apply:

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Ocular Injury | <input type="checkbox"/> Watering |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Flashes | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Floaters | <input type="checkbox"/> Loss of Vision |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eyestrain | |

Please sign below that you have reviewed all information above and that it is correct to the best of your knowledge.

X

Sign here

Date