PATIENT MEDICAL HISTORY

Matt Weaver, O.D.

(Please Print) **Today's Date_____**

Patient's Name_____
First MI Last

Date of Birth_____ Age_____ Sex Male or Female Phone_____
Cell or Home

Address_____City_____State_____Zip_____

Occupation_____Hobbies_____

CHOOSE ONE:
____Dilated Exam
____Exam with Optos® Retinal Image (No dilation needed)

____Contact Lens
____Glasses

CHECK ALL THAT APPLY TO YOU

GENERAL HEALTH			EYE HEALTH	
Anxiety			Allergies	
Arthritis			Cataracts	R / L / Both
Asthma			Dry Eyes	
COPD			Glasses	
Coronary Artery Disease			Glaucoma	R / L / Both
Depression			Macular Degeneration	R / L / Both
Diabetes			Retinal Tear or Detachment	R / L / Both
Hypertension (High Blood Pressure)			Floaters	R / L / Both
Thyroid Disease			Any Eye Surgery? Please list:	
Stroke			_____	
			Please Circle: Right eye Left eye Both eyes	

Please list current medications (or receptionist can make a copy if you have a list)

_____

_____

_____

Please list any medications you are allergic to._____

Are you currently using any eye drops, prescription or over-the-counter? Please list:_____

_____

Are you a smoker? Yes / No

Any family history of Glaucoma?_____ Any family history of Macular Degeneration?_____

Please list your primary healthcare physician_____