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_____

Type of Exam: Basic Exam_____ Dilated Exam_____ Contact Lens Exam_____
(Dilation gives the best views of the retinas and is necessary for diabetics or other eye conditions)

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_____