NEW EYES

_____ _____
Patient Name Date

Medical History

List Current Medications: _____

_____

Known Medical Allergies: _____

Have you ever had or are you currently being treated for any of the following conditions?	**Yes**	**No**	**If Yes, please explain**
Previous Surgeries	☐	☐	
Ear, Nose or Throat (hearing loss, sinus, any other ENT problems)	☐	☐	
Cardiovascular (heart problems, high blood pressure, cholesterol, chest pain)	☐	☐	
Respiratory (asthma, shortness of breath, lung problems)	☐	☐	
GI or GU (heartburn, diarrhea, vomiting, abdominal pain, kidney, urinary infection)	☐	☐	
Musculoskeletal (arthritis, muscle or joint pain and swelling)	☐	☐	
Skin (rash, cancer)	☐	☐	
Neurologic (stroke, headaches, numbness, weakness, paralysis)	☐	☐	
Psychiatric (anxiety, depression)	☐	☐	
Endocrine (diabetes, thyroid problems)	☐	☐	
Hematologic (blood disorders, anemia, leukemia, HIV+, AIDS, hepatitis)	☐	☐	
Allergic or Immunologic (allergies, hay fever or any other)	☐	☐	

Family and Social History: Is there a history of any of the following conditions in your family? Who?

☐ Diabetes _____ ☐ High Blood Pressure _____

Do you smoke? How much? _____ **Did you ever smoke?** When did you quit? _____

Do you live alone? Yes No

Height _____ **Weight** _____

_____ _____
Patient Signature Date