MEDICAL HISTORY

Name:_____ D.O.B:_____ Today's Date:_____

Height:_____ Weight:_____

Pharmacy:_____ City:_____

Medical Doctor (PCP):_____

Tobacco use: ____Current ____Former ____Never Type:_____

Do you have problems with or are being treated for: (Put an "X" by all that apply):

General: None:☐

Cancer (Type:_____)

(Status:_____)

Females: Currently pregnant ____

Gastrointestinal: None:☐

Ulcer _____

Reflux _____

Endocrine: None:☐

Hyperthyroidism _____

Hypothyroidism _____

Diabetic: Type I:____ Type II:____

(Year diagnosed:_____)

Skin: None: ☐

Eczema/Rosacea _____

Genitourinary: None: ☐

Prostate _____

Incontinence _____

Eyes: None:☐

Cataract/Glaucoma _____

Bell's Palsy _____

Eye injury _____

(Describe:_____)

Iritis _____

Macular Degeneration _____

Ears/nose/throat/mouth: None:☐

Chronic sinus or allergies _____

Hearing loss _____

Pulmonary: None:☐

Asthma _____

Emphysema _____

COPD _____

Oxygen _____

Sleep Apnea _____

Chronic Bronchitis _____

Cardiovascular: None:☐

Murmur _____

Palpitations _____

High blood pressure _____

Neurological: None:☐

Seizures (When:_____)

Paralysis _____

Stroke _____

Head injury _____

Multiple Sclerosis _____

Musculoskeletal: None:☐

Osteoporosis _____

Arthritis _____

Hematological: None:☐

Anemia _____

Hepatitis A:____ B:____ C:_____

Cholesteral _____

Immunologic: None:☐

Sjogrens syndrome _____

Lupus _____

Rheumatoid Arthritis _____

HIV/AIDS _____

Other conditions not mentioned above:_____

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Fry Eye Associates, P.A. vision for the tomorrows Garden City, KS

Phone: 620-275-7248
Website: www.fryeye.com
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MEDICAL HISTORY

Put an "X" by all that apply:

Dentures:	____ Yes or No	____ Full or Partial	____Upper	____Lower	____Both
Hearing aids:	____ Yes or No	____Right ear	____Left ear	____Both	

FAMILY HISTORY: M=Mother F=Father S=Siblings

DISEASE	YES	NO	RELATION	DISEASE	YES	NO	RELATION
Glaucoma				Cataracts			
Cancer				Arthritis			
Heart				Diabetes			
Hypertension				Kidney			
Lupus				Stroke			
Thyroid				Other			

MEDICATIONS: Bring a list of all medications, including over-the-counter meds to your appointment.

NAME	STRENGTH	HOW OFTEN	REASON FOR TAKING

Are you currently or have you ever taken Flomax? ___Yes ___No

Who prescribed this: _____

SURGICAL HISTORY:

SURGERY	DATE

ALLERGIES TO MEDICATIONS/BIOLOGICALS/MATERIALS:

PATIENT IS ALLERGIC TO:	TYPE OF REACTION	WHEN

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