Madison Eye Care, LLC
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MEDICAL HISTORY

Patient Name**:**_____ Date**:**_____

Primary Care Physician:_____ Date of Last Exam:___/___/___
Telephone:(___)_____-_____Address_____

1. **Are you currently infected with**: Cold virus, flu, HIV/AIDS, measles, chicken pox, herpes zoster, or any other infectious disease?

2. **Allergies to Medications: Yes/ No**. If yes, please list:

3. **Current Medications:**

4. **Females**: Are you pregnant or nursing? **YES/NO** How many months?_____

5. **Parents fill out for your child**: Prematurity, congenital conditions, Downs syndrome, autism, developmentally delayed, cerebral palsy, learning disabled, or other:

Are you being treated for any of the following disorders? (If yes, please list):

Dermatologic Disorders (rash, skin disease, other) **Yes/No**
Ear/Nose/Throat (Sinus, seasonal allergies, hearing problems) **Yes/No**
Cardiovascular (High blood pressure, cholesterol, heart disease) **Yes/No**
Respiratory (asthma, COPD, emphysema) **Yes/No**
Gastrointestinal (Digestive Disorders etc.) **Yes/No**
Endocrine (Diabetes, Thyroid, other) **Yes/No**
Neurologic (MS, Cerebral Palsy, stroke, headache) **Yes/No**
Cancer Yes/No
Musculoskeletal (Arthritis, muscle disease, other) **Yes/No**
Psychiatric Well-Being (Depression, anxiety, other) **Yes/No**
Genito-urinary/Reproductive (Bladder/urinary problems, hormone imbalance) **Yes/No**

History of Surgery: (Please list dates):

History of Eye Surgery (dates):

Family Medical History (systemic and ocular):

Patient Signature:_____ Date:_____