PATIENT MEDICAL HISTORY

NAME _____ **Age** _____ **Sex** _____ **Date** _____

HAVE YOU BEEN TREATED FOR: (✓ the ones that apply.)

Diabetes	____	Osteoporosis	____
Heart Disease	____	Lung Disease	____
High Blood Pressure	____	Skin Problems (Describe)	____
High Cholesterol	____	Gastrointestinal	____
Urological (Describe)	____	Cancer (Describe)	____
Arthritis	____	Eye Problems (Describe)	____
Anxiety	____	Cataract	____
Depression	____	Macular Degeneration	____
Neurological (Describe)	____	Glaucoma	____
Other (Describe)	____	Retinal Detachment	____

Describe: _____
_____
_____

LIST ALL PRESCRIPTION MEDICATIONS:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

SOCIAL HABITS: (✓ the ones that apply.)

Do you smoke? _____ How much? _____
Do you drink? _____ How much? _____

FAMILY HISTORY: (✓the ones that apply.)

Diabetes _____ High Blood Pressure _____ Glaucoma _____ Cancer _____

LIST ANY <u>DRUG</u> ALLERGIES:

_____ _____ _____

_____ _____ _____
Patient Signature **Dr. Archana Gupta** Date