# CECA Patient Medical History Information

Patient Name_____DOB_____ Date _____

## Medical History (Circle items that apply to you)

Environmental Allergies
Anemia
Anxiety
Arthritis
Asthma
Back Problems
Bleeding Disorder
Cholesterol Disorder
Cancer _____
Chest Pain
Depression
Diabetes_____
Frequent Headaches
Fuch's Dystrophy
Glandular/hormone problem
Hearing Problem/Deaf
Heart Disease/Pacemaker
Heart Murmur
Hepatitis_____
HIV
High Blood Pressure
Joint Pain
Kidney Disorder
Lung Disease_____
Lupus
Melanoma
Memory Problem_____
Numbness/tingling
Osteoporosis/Osteopenia
Prostate Disorder
Recent Weight Change
Sarcoidosis
Seizures
Shortness of breath
Sjogrens Syndrome
Stomach/ Digestive Issues
Stroke
Thyroid Disorder_____
Vertigo / Dizziness
Other_____

## Social History (circle items that apply to you)

Alcohol Use: No Rarely Occasionally Daily/Weekly _____ # Glasses
Tobacco Use: Never Quit ____ years Currently Smoke _____ packs a day for _____ #of years
Recreational Drug Use: No Yes Type/frequency_____

## Past Medical Surgery

| Type of Surgery | Date of Procedure |
|---|---|
| | |
| | |

## Past Eye Surgery, Disease or Injury

| Type of Surgery | Date of Procedure |
|---|---|
| | |
| | |
| | |

## Family MembersEye Medical History

| Eye Disease | Relationship |
|---|---|
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| | |
| | |

## Your Vision and Eye History

| Vision Correction | Yes | No | # of Years |
|---|---|---|---|
| Glasses | | | |
| Contact lenses | | | |
| Mono-Vision Contacts | | | |
| Lasik | | | |

# Prescription Medication Information Sheet

## Medication List

| Medicine Name | Daily Dosage (mg., ml.) | Reason for taking |
|---|---|---|
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## Eye Medication List

| Eye Drop | Reason for taking | # of times per Day | Which Eye |
|---|---|---|---|
| | | | |
| | | | |
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## Drug Allergies

| Allergy | Reaction |
|---|---|
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## List of Other Physicians/Specialists involved in your care

| Physician Name | Specialty Type | Phone# |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Please List your Preferred Pharmacy Refill Location and Information

Pharmacy Name _____Location_____

Phone _____ Fax _____