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 Jennifer Loh, M.D. Date