MEDICAL HISTORY FORM

NAME: | **FILE NO:**

DOB:

REFERRING DR:					**OPTOMETRIST**
GLASSES	**YES**		**NO**		**SINCE WHEN?**

GENERAL PRACTIONER:

EMPLOYMENT: TYPE OF JOB/RETIRED?

DO YOU DRIVE? | **DATE LICENCE DUE FOR RENEWAL?**

MEDICAL HISTORY:	
HYPERTENSION:	
DIABETES:	
CHOLESTEROL:	
ASTHMA:	
ARTHRITIS:	

OTHER MEDICAL AND SURGICAL HISTORY:

FAMILY MEDICAL HISTORY:

FAMILY EYE HISTORY:

ALLERGIES:

CURRENT MEDICATIONS-DO YOU TAKE:

DISPRIN/ASPRIN:		
ECOTRIN:		
PLAVIX: (CLOPIDOGREL)		
XARELTO:		
INSULIN:		
PROSTATE MEDICATION: (EG. FLOMAX)		
ANTI-INFLAMMATORIES:		
OMEGA 3:		
ARNICA:		
ANY OTHER MEDICATION:		

	DOSEAGE:		FREQUENCY: