Tehachapi Optometric Center
Patient Medical History

Today's Date: _____

Name:_____ Birth Date: _____ Age: _____ Sex: M F

Occupation: _____ Hobbies: _____ Height:_____ Weight:_____

Tobacco Use: Yes / No How Much: _____

Allergies to Medication or Painkillers: List: _____

Current Medications and/or Eye Drops: (Regular or Occasional Use, Prescription and Non-Prescription)

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Name of Regular Medical Doctor: _____

Are you under any other Doctor's Care? Yes / No Name: _____

Reason: _____

Do You Have, or Have You Had Any of the Following:

- ☐ Allergies / Hayfever
- ☐ Arthritis Date of Diagnosis: _____
- ☐ Asthma
- ☐ Cancer What type: _____
- ☐ Diabetes Date of Diagnosis: _____
- ☐ Dizzy Spells / Fainting
- ☐ Glaucoma
- ☐ Head / Neck Injury When: _____
- ☐ Heart / Circulation Problems
- ☐ Hepatitis Type: A B C D E
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive or AIDS
- ☐ Neurological Disease / Parkinson's
- ☐ Seizures / Epilepsy
- ☐ Skin Disorders / Rashes
- ☐ Stroke When: _____
- ☐ Tuberculosis

Any Other Significant Medical Conditions? _____

Have You Had Any Eye Surgeries? List: _____

Are You Pregnant: Yes / No Nursing: Yes / No

Do You Have a Blood-Related Family Member With Any of the Following?

☐ Blindness Who: _____ Caused By? _____

☐ Glaucoma Who: _____

☐ Diabetes Who: _____