Horizon Eye Care Group, P.C. **Medical History**

First Name: _____ Last Name: _____

Are you allergic to any known medications? ☐ **Yes** ☐ **No**

If yes, please list medications: _____

General Health: (*Circle one)*

Do you have diabetes? Yes No

Do you have high blood pressure? Yes No

Do you have heart disease? Yes No

Do you see a rheumatologist? Yes No

If yes, why? _____

Do you smoke daily? Yes No

Do you drink alcohol on a daily basis? Yes No

Please list any other medical conditions that you have: _____

_____

Height: _____ Weight: _____

Eye Health: (*Circle one)*

Have you been previously treated for any eye conditions? Yes No

If yes, list those eye conditions: _____

Have you ever had an eye injury or eye operation? Yes No

If yes, please list those: _____

Please list any medications that you take:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Continue medication on back if necessary