

**BARNHORST EYE ASSOCIATES**  
**Medical/Social History**

Patient name: \_\_\_\_\_

**Past Surgical History (list any type of surgery you have had or indicate "NONE")**


**Social History**

Current Occupation: \_\_\_\_\_ Marital Status: M / D / S / W Do you drive? Yes / No  
 Alcohol use: Never / Occasional / Daily Do you smoke? \_\_\_\_ Yes \_\_\_\_ No <1ppd / >1ppd  
 Do you have: HIV / Hepatitis (type\_\_\_\_) / No

Have you ever had an allergic reaction to a medication? \_\_\_\_ Yes \_\_\_\_ No

Name of medication you are allergic to:	Reaction:

**Medications**

Please list any medications/supplements you are currently taking below or indicate "NONE":


**Personal Medical/Family History**

Do you or any of the listed family members have/had any of the following?:

Medical Condition	Patient	M-Mother F-Father S-Sibling GP-Grandparent
Endocrine (diabetes, thyroid, etc.)	Y / N	Y / N
Cardiovascular (heart, high blood pressure, etc.)	Y / N	Y / N
Respiratory (asthma, emphysema, COPD, etc.)	Y / N	Y / N
Gastrointestinal (stomach ulcers, intestinal disease, etc.)	Y / N	Y / N
Genital, Urinary, Kidney (prostate)	Y / N	Y / N
Bone, Joint, Muscular (arthritis, etc.)	Y / N	Y / N
Skin (acne, rash, cancer, warts, etc.)	Y / N	Y / N
Neurological (multiple sclerosis, etc.)	Y / N	Y / N
Allergic, Immunologic (hay fever, lupus, sjogren's, etc.)	Y / N	Y / N
Blood, Lymph (anemia, cholesterol, etc.)	Y / N	Y / N
Cancer – specify type ( )	Y / N	Y / N
Psychiatric (anxiety, depression, etc.)	Y / N	Y / N
General / Constitutional ( fever, weight change, fatigue, etc.)	Y / N	Y / N
Other – specify ( )	Y / N	Y / N
Cataracts	Y / N	Y / N
Glaucoma	Y / N	Y / N
Macular Degeneration	Y / N	Y / N

**Staff initials and Date:** \_\_\_\_\_

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**Staff initials and Date:** \_\_\_\_\_