CLARUS
VISION CLINIC

Personal Medical History

Date _____

Name: _____ **Age:** _____

Preferred Pharmacy: _____ **Pharmacy Location:** _____

Referring Physician _____ Family Physician _____

The **main reason** I came in today is _____

I want to specifically ask the doctor about _____

Allergies (or reactions) to medication _____ No Known Drug Allergies

List all medications you are now taking **(include non-prescription drugs, vitamins, insulin, eye drops)** or let us photocopy your list. ☐ Medication list attached

Name of Medication	Purpose of Medication

List all major surgeries (including **eye surgeries**) you have had:

Type of Surgery	Date	Type of Surgery	Date

(Over to other side of this page)

Please check either yes or no for each question:

Personal Medical History	Yes	No	Please Explain Your Problem
Endocrine (e.g. diabetes, thyroid)			
Heart (e.g. high blood pressure, phlebitis)			
Neurological (e.g. seizures, strokes, palsy, numbness)			
Urological (e.g. kidney, bladder, prostate)			
Respiratory (e.g. asthma, emphysema, oxygen use)			
Gastrointestinal (e.g. bleeding, ulcer, polyps)			
Cancer (e.g. all types of cancer & history)			
Musculoskeletal (e.g. deformities, muscles, arthritis)			
Hematological (e.g. anemia, easy bleeding)			
Infections (e.g. hepatitis, HIV/AIDS, recent influenza)			
Skin (e.g. rash, open sores)			
Psychiatric (e.g. depression, claustrophobia)			
Immunologic (e.g. hay fever, lupus)			
Constitutional (e.g. fevers, aches, etc.)			
Other Problems (e.g. recent hospitalization, injuries)			

Family History: Please write in the relationship of the family member to you

Blindness _____ Color/ Night Vision Loss _____

Macular Degeneration _____ Other Eye Problems _____

Diabetes _____ Heart Disease _____

Stroke _____ Cancer _____

Other _____

Social History:

Current or Former Occupation _____ Retired

Do you use tobacco? _____Yes _____ No _____Packs/day _____Years
Do you drink alcoholic beverages? _____Yes _____ No _____Times/wk _____Years _____Type
Do you drive? _____Yes _____ No

Patient Signature _____

Physician Signature _____