DOCTORS EYECARE CENTERS

Robert G. LeSage, OD & Timothy E. Underhill, OD

PATIENT HISTORY

Patient Name:____ Date:________________________

DO YOU OR ANY OF YOUR IMMEDIATE FAMILY HAVE ANY OF THE FOLLOWING?

CONDITIONS	YOU	MOTHER	FATHER	BROTHER	SISTER	CHILD	COMMENTS
USE ALCOHOL							
USE TOBACCO							
ALLERGIES							
ARTHRITIS							
ASTHMA							
DIABETES							
HEART DISEASE							
HYPERTENSION							
HYPERCHOLESTEROL							
STROKE							
THYROID DISEASE							
CATARACT							
GLAUCOMA							
MACULAR DEGEN.							

HEIGHT:________________________________ **WEIGHT:**______________________________

LIST MEDICINES TAKEN WITH DOSAGE

____ ____

____ ____

____ ____

____ ____

EYE SURGERIES **DATE**

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