INTERMOUNTAIN EYE CENTERS (Form A)

NAME:	DATE:
MEDICAL HISTORY (List all medi	ical problems, including past surgeries):
FAMILY HISTORY (Parents, grand	lparents or siblings with macular degeneration, glaucoma, cataract or diabetes):
·	llergies to medications and type of reaction):
MEDICATIONS (Include aspirin, vit	amins, birth control pills, etc.):
MEDICAL DEVIEW (C)	
MEDICAL REVIEW (Check any pr Constitutional: Weight Gain Weight Loss Chronic Fatigue Ears / Nose / Throat: Loss of Hearing Sinus Problems Swollen Glands Nosebleeds Allergy / Immunity:	Heart / Circulation: Chest Pain Irregular Heartbeat Sleep With Extra Pillows Extremity Swelling High Blood Pressure Musculoskeletal: Painful Joints Integumentary: Rashes Costeoporosis Arthritis Endocrine: Neurological:
☐ Environmental Allergies ☐ Lupus	□ Diabetes □ Numbness / Weakness □ Hormone Therapy □ Loss of Memory □ Thyroid Disease □ Raynaud's
Urinary Tract: ☐ Painful Urination ☐ Incontinence	Respiratory: Shortness of Breath Wheezing Coughing Doyou use tobacco? ✓ YES ✓ NO How much? Doyou use alcohol? ✓ YES ✓ NO How much?
FORM UPDATED	All unmarked systems WNL Eye History see Form B