St. Cloud Eye Clinic
COMPREHENSIVE EYE CARE FOR OVER 80 YEARS

Medical History

Steven W. Rice, M.D., F.A.C.S.
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Bradley M. Anderson, M.D.
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Name _____ Date of Birth ____/____/____ Sex ☐ M ☐ F
Last First MI

Preferred pharmacy _____

Medical History
Please answer the following question by circling "yes" or "no". Please answer all questions.

Medical Problem

Cataracts	yes	no	Lungs	yes	no
Glaucoma	yes	no	Stomach / bowel	yes	no
Retina	yes	no	Kidney / bladder	yes	no
Strabismus (lazy eye)	yes	no	Bones / muscle	yes	no
Heart Disease	yes	no	Brain (tumor / stroke)	yes	no
High Blood Pressure	yes	no	Skin (rash / growth)	yes	no
Thyroid	yes	no	Blood disorder	yes	no
High Cholesterol	yes	no	Other eye problems?	yes	no

Family History
Has any relative had any of the following:

Cataracts	yes	no	relation: _____
Glaucoma	yes	no	relation: _____
Retina detachment	yes	no	relation: _____
Macular degeneration	yes	no	relation: _____
Diabetes	yes	no	relation: _____

Please list ALL previous surgical procedures:

1. _____ 3. _____
2. _____ 4. _____

Current Medications:
(Include over-the-counter)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have any allergies? ☐ yes (list) ☐ no
(Include medications)

1. _____
2. _____
3. _____
4. _____
5. _____

If additional medications are needed to be listed, write on back of this form or bring in a copy.

Social History

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Significant Other: _____

List any disability: _____

Do you consume alcohol? ☐ Yes ☐ No If Yes, how often and how much? _____

Do you smoke? ☐ Yes ☐ No ☐ Former smoker

Do you consume caffeine? ☐ Yes ☐ No If Yes, how many cups daily? _____

St. Cloud Eye Clinic
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