

**GENE GADDY, M.D.**

**Medical History**

**PLEASE PRINT**

Name \_\_\_\_\_ Date \_\_\_\_\_

What concerns if any do you have about your eyes? \_\_\_\_\_

Have you ever had eye surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

Have you ever had an eye injury? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

List all: Medications \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Allergies \_\_\_\_\_  
\_\_\_\_\_

Do you or any blood relatives have any of the following:

(Mark "S" for Self, "R" for relative.)

- |                                 |                           |                            |
|---------------------------------|---------------------------|----------------------------|
| _____ heart disease             | _____ blindness           | _____ macular degeneration |
| _____ glaucoma                  | _____ retinal detachment  | _____ diabetes             |
| _____ stroke                    | _____ high cholesterol    | _____ arthritis            |
| _____ cancer                    | _____ high blood pressure | _____ thyroid disease      |
| _____ other (please list) _____ |                           |                            |

Please list all surgical procedures you have had in the past: \_\_\_\_\_

Do you have an optometrist? \_\_\_ Yes \_\_\_ No If yes, please list: \_\_\_\_\_

Do you wear glasses or contact lenses? \_\_\_ Yes \_\_\_ No If so, for how long? \_\_\_\_\_

Do you smoke? \_\_\_ Yes \_\_\_ No Do you use alcohol? \_\_\_ Yes \_\_\_ No

Are you pregnant? \_\_\_ Yes \_\_\_ No If yes, how often? \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Guardian Date