OPHTHALMIC ASSOCIATES OF BILLINGS, L.L.C.
4033 Avenue B
BILLINGS, MT 59106

MEDICAL HISTORY

NAME:_____ DATE:_____

SELF	FAMILY		SELF	FAMILY	
____	____	FEVER, FATIGUE, MALAISE	____	____	CANCER
____	____	EAR DISORDER	____	____	THYROID/ENDOCRINE
____	____	NOSE DISORDER	____	____	INTESTINAL/STOMACH
____	____	MOUTH DISORDER	____	____	BLOOD/LYMPHATICS
____	____	THROAT DISORDER	____	____	SKIN DISORDER
____	____	HEART DISORDER	____	____	MIGRAINES
____	____	MUSCLE/BONE/JOINT	____	____	DIABETES
____	____	HIGH BLOOD PRESSURE	____	____	ALLERGIES/IMMUNE
____	____	NERVE/NEUROLOGIC DISORDER	____	____	MENTAL ILLNESS / PSYCHIATRIC
____	____	URINARY/BLADDER/PROSTATE			
____	____	BREATHING/LUNGS	____	____	OTHER ILLNESS / CONDITION

PLEASE LIST ANY OTHER EXISTING HEALTH CONDITIONS_____
_____
PRESENT PRIMARY CARE PHYSICIAN_____
MEDICATIONS_____
_____
DRUG ALLERGIES _____
PREGNANT Y OR N _____
HAVE YOU HAD ANY GENERAL SURGERY Y OR N, IF YES PLEASE LIST_____

OCULAR HISTORY

SELF	FAMILY		SELF	FAMILY	
____	____	GLAUCOMA	____	____	EYE INFECTIONS
____	____	CATARACT	____	____	FLASHES
____	____	MACULAR DEGENERATION	____	____	SPOTS
____	____	CROSSED EYES	____	____	HALOES
____	____	AMBLYOPIA/LAZY EYE	____	____	DOUBLE VISION
____	____	RETINAL PROBLEMS	____	____	BLURRED VISION
____	____	EYE INJURIES			

PLEASE LIST ANY OTHER OCULAR CONDITIONS OR SYMPTOMS NOT PREVIOUSLY LISTED_____
I PRESENTLY WEAR GLASSES CONTACT LENSES NEITHER
DATE OF LAST EYE EXAM_____

SOCIAL HISTORY

YES	NO		
____	____	ALCOHOL USE	PLEASE SPECIFY_____
____	____	TOBACCO USE	PLEASE SPECIFY_____
____	____	DRUG USE	PLEASE SPECIFY_____