



PATIENT MEDICAL HISTORY

Name		Nickname		Date
Family Member			Referring Doctor	
Date of Birth	Age	Home Phone	Cell Phone	
Past Eye Disease/Injuries: <input type="radio"/> No <input type="radio"/> Yes, Please Describe:				
Other surgeries: <input type="radio"/> No <input type="radio"/> Yes, Please Describe:				
Eye Medications: <input type="radio"/> No <input type="radio"/> Yes, Please Describe:				
Allergies to Food, Medications or Latex: <input type="radio"/> No <input type="radio"/> Yes, Please Describe:				
Eye Disease: Have you ever had any eye disease? If yes, please explain and include the year diagnosed.				
<input type="radio"/> No	<input type="radio"/> Yes	Cataract _____		
<input type="radio"/> No	<input type="radio"/> Yes	Corneal Disease or Transplant _____		
<input type="radio"/> No	<input type="radio"/> Yes	Diabetic Eye Disease _____		
<input type="radio"/> No	<input type="radio"/> Yes	Glaucoma _____		
<input type="radio"/> No	<input type="radio"/> Yes	Lazy Eye (Amblyopia) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Macular Degeneration _____		
<input type="radio"/> No	<input type="radio"/> Yes	Muscle Disorder (Crossed Eye) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Retinal Detachment or Hole _____		
<input type="radio"/> No	<input type="radio"/> Yes	Injury _____		
<input type="radio"/> No	<input type="radio"/> Yes	Surgery or Laser _____		
Have you ever been treated for any of the following medical conditions? Please check yes or no and circle all that apply. Explain further in the space provided if necessary:				
<input type="radio"/> No	<input type="radio"/> Yes	Arthritis (Rheumatoid, Osteo-degenerative) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Blood Disease (Anemia, Leukemia, Clotting problems) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Ear, Nose, Throat (Hearing Loss, Sinus Disease) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Diabetes (Type, how controlled and when diagnosed) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Thyroid Disease (Hypo, Hyper, Graves Disease) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Lung Disease (Asthma, Emphysema, COPD, Chronic Bronchitis) _____		
<input type="radio"/> No	<input type="radio"/> Yes	High Blood Pressure _____		
<input type="radio"/> No	<input type="radio"/> Yes	Gastrointestinal Disease (Ulcers, Esophageal Reflux, Intestinal or Liver Disease) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Neurological Problems (Stroke, Mini Strokes, Seizures, Paralysis) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Skin Disease (Eczema, Psoriasis, Acne, Rosacea) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Mental Health (Depression, Anxiety, Schizophrenia, Bipolar) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Cancer (List Type or Location and Date) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Infectious Disease (TB, Syphilis, Gonorrhea, AIDS, HIV, Hepatitis, MRSA) _____		
<input type="radio"/> No	<input type="radio"/> Yes	Other Problems _____		

PLEASE CONTINUE THIS FORM ON THE BACK →

Review of Symptoms: Do you currently have any of the following problems? Check all that apply.

- No Yes Fever or Weight Loss/Fatigue_____
- No Yes Ear/Nose/Throat (Hearing Loss/Sinus)_____
- No Yes Cardiovascular (Chest Pain, Irregular Heartbeat)_____
- No Yes Respiratory (Shortness of Breath, Wheezing)_____
- No Yes Urinary Problems (Pain or Discomfort, Blood)_____
- No Yes Skin Problems (Rashes, Excessive Dryness)_____
- No Yes Musculoskeletal (Muscle Aches, Arthritis)_____
- No Yes Neurological (Numbness, Weakness, Headaches)_____
- No Yes Hematologic (Bleeding Tendencies, Anemia)_____
- No Yes Gastrointestinal (Heartburn, Abdominal Pain, Diarrhea)_____
- No Yes Allergic/Immunologic (Seasonal Allergies, Hay Fever)_____
- No Yes Psychiatric Problems (Depression, Anxiety)_____

Family History of Disease:

Do you have a family history of any of the following diseases? Relative affected(mother, father, sister, etc.)

- No Yes Diabetes_____
- No Yes Glaucoma_____
- No Yes Retinal Disease_____

Social History:

Do you use tobacco products? No Yes _____ packs/day

Do you consume alcohol? No Yes _____ drinks/day

Do you work outside the home? No Yes _____ hours/wk

MEDICATION LIST

Please list all medications you take (including over-the-counter medicine and birth control pills)

Name of Medicine	For What Problem is the Medicine Taken?

Patient Signature:

Physician Signature:

Date: