Surgical Eye Care, P.A. **Alan W. Brown, M.D.**

PATIENT MEDICAL HISTORY

Name		Nickname	Date
Family Member		Referring Doctor	
Date of Birth	Age	Home Phone	Cell Phone

Past Eye Disease/Injuries:
O No **O** Yes, Please Describe:

Other surgeries:
O No **O** Yes, Please Describe:

Eye Medications:
O No **O** Yes, Please Describe:

Allergies to Food, Medications or Latex:
O No **O** Yes, Please Describe:

Eye Disease:
Have you ever had any eye disease? If yes, please explain and include the year diagnosed.

O No **O** Yes Cataract_____
O No **O** Yes Corneal Disease or Transplant_____
O No **O** Yes Diabetic Eye Disease_____
O No **O** Yes Glaucoma_____
O No **O** Yes Lazy Eye (Amblyopia) _____
O No **O** Yes Macular Degeneration_____
O No **O** Yes Muscle Disorder (Crossed Eye) _____
O No **O** Yes Retinal Detachment or Hole_____
O No **O** Yes Injury_____
O No **O** 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:

O No **O** Yes Arthritis (Rheumatoid, Osteo-degenerative)_____
O No **O** Yes Blood Disease (Anemia, Leukemia, Clotting problems)_____
O No **O** Yes Ear, Nose, Throat (Hearing Loss, Sinus Disease)_____
O No **O** Yes Diabetes (Type, how controlled and when diagnosed)_____
O No **O** Yes Thyroid Disease (Hypo, Hyper, Graves Disease)_____
O No **O** Yes Lung Disease (Asthma, Emphysema, COPD, Chronic Bronchitis) _____
O No **O** Yes High Blood Pressure_____
O No **O** Yes Gastrointestinal Disease (Ulcers, Esophageal Reflux, Intestinal or Liver Disease) _____
O No **O** Yes Neurological Problems (Stroke, Mini Strokes, Seizures, Paralysis)_____
O No **O** Yes Skin Disease (Eczema, Psoriasis, Acne, Rosacea)_____
O No **O** Yes Mental Health (Depression, Anxiety, Schizophrenia, Bipolor)_____
O No **O** Yes Cancer (List Type or Location and Date)_____
O No **O** Yes Infectious Disease (TB, Syphilis, Gonorrhea, AIDS, HIV, Hepatitis, MRSA)_____
O No **O** 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.

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

O No **O** Yes Diabetes_____
O No **O** Yes Glaucoma_____
O No **O** Yes Retinal Disease_____

Social History:

Do you use tobacco products? **O** No **O** Yes _____packs/day
Do you consume alcohol? **O** No **O** Yes _____drinks/day
Do you work outside the home? **O** No **O** 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: