



PATIENT MEDICAL HISTORY

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

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

Other surgeries:
 No Yes, Please Describe:

Eye Medications:
 No Yes, Please Describe:

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

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

No Yes Cataract _____
 No Yes Corneal Disease or Transplant _____
 No Yes Diabetic Eye Disease _____
 No Yes Glaucoma _____
 No Yes Lazy Eye (Amblyopia) _____
 No Yes Macular Degeneration _____
 No Yes Muscle Disorder (Crossed Eye) _____
 No Yes Retinal Detachment or Hole _____
 No Yes Injury _____
 No 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:

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