PATIENT MEDICAL HISTORY

NAME_____ **DOB**_____

MEDICAL STATUS AND HISTORY:

Do you have any food or drug **allergies**? YES___NO___list_____
Do you take any **EYE medications**? YES___NO___list_____
Do you take any **OTHER medications**? YES___NO___list names and dosages here_____

_____

_____

Have you ever had any of the following **EYE** diseases?

GLAUCOMA YES___NO___ MACULAR DEGENERATION YES___NO___
LAZY EYE (turn) YES___NO___ DIABETIC RETINOPATHY YES___NO___
CATARACTS YES___NO___ RETINAL DETACHMENT YES___NO___

Have you ever had **eye surgery, injections, treatments,** or **laser procedures**? YES___NO___ list_____

_____

Have you ever been treated for **DIABETES**? YES___NO___ If so, for how many years?_____

CIRCLE if *you might have*, or ever have been treated for any of the following **medical conditions.**

Aids/HIV
Alzheimers or Dementia
Anemia
Arthritis
Asthma
Blood disorder
Cancer
Genetic disorder
Heart disease
High blood pressure
Kidney disease
Liver disease
Stroke
Thyroid disease
Ulcers
OTHER CONDITION_____

Have you ever been **hospitalized** or had **major surgery**? YES___NO___list_____

_____

REVIEW OF SYSTEMS: **CIRCLE.....YES** if you ***currently*** have any of the following problems or **NO** if you do not.

Chronic fever, weight loss/gain, fatigue	yes	no	
Ear, Nose, or Throat problems	yes	no	(ie. hearing loss, sinuses)
Heart problems	yes	no	(ie. chest pain, irregular heart beat)
Respiratory problems	yes	no	(ie. shortness of breath)
Gastrointestinal problems	yes	no	(ie. heartburn, abdominal pain)
Urinary problems	yes	no	(ie. pain, blood in the urine)
Skin problems	yes	no	(ie. rashes)
Musculoskeletal problems	yes	no	(ie. pain, swelling in joints)
Neurologic problems	yes	no	(ie. numbness, weakness, headaches)
Psychiatric problems	yes	no	(ie. depression, anxiety)

FAMILY and SOCIAL HISTORY:

Do any medical or eye diseases run in your **family?** (ie. Diabetes, high blood pressure, macular degeneration, retinal detachment) YES___NO___list_____
Do you **smoke**? YES___NO___how much?_____
Do you **drink**? YES___NO___how much?_____

DATE TODAY_____