PATIENT MEDICAL HISTORY

Patient Name: _____ Sex: ___ Date of Birth: _____ Date: _____

Referring Eye Doctor: _____ Address: _____

Medical Doctor: _____ Address: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Present Illness Please describe your current eye problem:

_____

_____

OCULAR HISTORY

Have you ever had any of the following?

Cataract Surgery: ☐ Right eye ☐ Left eye Surgeon & Date: _____

Macular Degeneration: ☐ Right eye ☐ Left eye

Glaucoma: ☐ Right eye ☐ Left eye

Retinal Detachment: ☐ Right eye ☐ Left eye If yes, please explain:

_____

_____

Other Eye Conditions: _____

MEDICAL HISOTRY *(Please check all that apply)*

Pregnant ☐ Yes ☐ No

Pneumonia Vaccine ☐ Yes ☐ No

Flu Vaccine ☐ Yes ☐ No For current or upcoming flu season

High Blood Pressure ☐ Yes ☐ No Controlled with Medication: ☐ Yes ☐ No

High Cholesterol ☐ Yes ☐ No

Heart problems ☐ Yes ☐ No ☐ Heart attack ☐ Angina ☐ Rhythm Problems
☐ Congestive Heart Failure ☐ Other: _____

Neurology ☐ Yes ☐ No ☐ Stroke ☐ Seizures ☐ Migraine
☐ Parkinson's ☐ Neuropathy ☐ Bells Palsy
☐ Mini Stroke (TIA) ☐ Dementia

Endocrine ☐ Yes ☐ No ☐ Diabetes Type I Type II How long? _____
Last blood Sugar _____ Last A1C_____
☐ Thyroid Disease

Pulmonary ☐ Yes ☐ No ☐ Asthma ☐ Emphysema ☐ COPD
☐ Tuberculosis ☐ Pulmonary Embolism

Genitourinary ☐ Yes ☐ No ☐ Enlarged Prostate ☐ Kidney Disease
☐ Kidney Stones

Gastroenterology ☐ Yes ☐ No ☐ GERD-Reflux ☐ IBS ☐ Ulcers ☐ Hiatal Hernia
☐ Diverticulitis ☐ Crohn's Disease

Hematology ☐ Yes ☐ No ☐ Anemia ☐ Hepatitis ☐ Lyme Disease
☐ Sickle Cell Disease ☐ HIV
☐ Cancer: If so, what type_____

Rheumatology ☐ Yes ☐ No ☐ Rheumatoid Arthritis ☐ Sjogren's Syndrome
☐ Lupus ☐ Auto Immune Disorder

Psychiatry ☐ Yes ☐ No ☐ Depression ☐ Anxiety ☐ Other:_____

Other medical problems not listed above:

_____
_____
_____

SURGICAL HISTORY ☐ Yes ☐ No ☐ Gallbladder ☐ Appendectomy
☐ Hysterectomy ☐ Bypass – CABG
☐ Hernia – Herniorrhaphy ☐ Tonsillectomy
☐ Pacemaker ☐ Other: _____

ALLERGIES

Medication ☐ Yes ☐ No

Please list medication allergies and symptoms:

_____
_____
_____

Food ☐ Yes ☐ No _____

FAMILY HISTORY

Is there an eye disease/problem which runs in your family? ☐ Yes ☐ No

Please list the family relationship for any eye disease/problem you select

☐ Macular Degeneration Relationship: _____
☐ Retinal Detachment Relationship: _____
☐ Glaucoma Relationship: _____
☐ Cataracts Relationship: _____

Is there any significant medical disease which runs in your family? ☐ Yes ☐ No

Please list the family relationship for any medical disease you select

☐ High Blood Pressure Relationship: _____
☐ Heart Disease Relationship: _____
☐ Lung Disease Relationship: _____
☐ Kidney Disease Relationship: _____
☐ Cancer Relationship: _____
☐ Diabetes Relationship: _____