

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 Heart disease
Alzheimers or Dementia High blood pressure
Anemia Kidney disease
Arthritis Liver disease
Asthma Stroke
Blood disorder Thyroid disease
Cancer Ulcers
Genetic disorder 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? \_\_\_\_\_

Record reviewed date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

RETINA PHYSICIAN signature \_\_\_\_\_ DATE TODAY \_\_\_\_\_