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___
LazyEye(Turn) YES___ NO___ DIABETIC RETINOPATHY YES___ NO___
CATARACTS YES___ NO___ RETINALDETACHMENT 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?________________________

CHECK OFF 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: **CHECK OFF…..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**_______________