PATIENT MEDICAL HISTORY

Name _____ Today's Date _____

Date of Last Eye Exam _____ Eye Doctor _____ Treatment _____

Date of Last Medical Exam_____ Medical Doctor_____ Dr's Phone #_____

Please fill out information completely and check ANY boxes that apply to you. If you need more space please use backside of page.

Eye Health History

(please note any problems the you have experienced)

		Date Diagnosed
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Blindness		
Strabismus		
Floaters/Flashes		
Other Eye Disease		

Family History

(please note any family history of the following)

		Relationship
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Strabismus		
Lazy Eye		
Diabetes		
Cancer		
Heart Disease		
Other: _____		

Social History

(this information is kept strictly confidential)

		type/amount1/how long
Tobacco		
Illegal Drugs		
Alcohol		

Have you ever been infected with or exposed to:

Gonorrhea	
Hepatitis	
Syphilis	
HIV	

Allergies

(Please list any allergies: medication and/or enviromental)

Allergic to:

Reaction:

MEDICATION LIST

(list all medication that you are currently taking including oral contraceptives, aspirin, over the counter medications and home remedies) Include dose & frequency

Review of Systems

(Please indicate any that apply)

CARDIOVASCULAR		**EAR, NOSE, MOUTH, THROAT**	
Bypass surgery		Seasonal Allergies	
Congestive Heart Failure		Chronic Allergies	
Heart disease		Sinus infections/congestion	
High cholesterol		Dry throat/mouth	
High Blood Pressure		**RESPIRATORY**	
Stroke		Asthma	
ENDOCRINE		Bronchitis	
Diabetes - Insulin		COPD	
Diabetes - Oral		Emphysema	
Diabetes - Diet		Chronic cough	
Borderline Diabetes		Lung cancer	
Hyperthyroidism		Sarcoidosis	
Hypothyroidism		Tuberculosis	
Adrenal Gland Dysfunction		**GASTROINTESTIONAL**	
Menopausal Symptoms		Crohn's Disease	
EYES		Ulcerative colitis	
Loss of vision		GERD (heartburn)	
Double Vision		Hepatitis	
Discharge/excess tearing		Jaundice	
Sandy/gritty sensation		**GENITOURINARY**	
Dry/Burning		Kidney failure / dialysis	
Red/Itchy		Prostate hypertrophy	
Floaters/Flashes		Cancer	
Glare/light sensitivity		**BONES / JOINTS / MUSCLES**	
Eye pain/chronic infection		Arthritis	
Tired Eyes		Rheumatoid Arthritis	
CONSTITUTIONAL		Joint pain	
Fever		**LYMPHATIC / HEMATOLOGIC**	
Sudden Weight gain/loss		Anemia	
INTEGUMENTARY (skin)		Sickle Cell	
Eczema		Prolonged bleeding time	
Psoriasis		**IMMUNOLOGICAL**	
Skin Cancer		Collagen vascular disease	
NEUROLOGICAL		Ankylosing spondilitis	
Headaches		Lupus	
Migraine		Sarcoidosis	
Bell's Palsy		Sjorgrens Syndrome	
Horner's Syndrome		Stevens Johnson Syndrome	
Seizures		**PSYCHIATRIC**	
Stroke		Mood Disorders	
Multiple Sclerosis		Depression	
Parkinson's Disease			

OTHER (Please List)