

**MEDICAL HISTORY**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date \_\_\_\_\_

Patient Signature \_\_\_\_\_

Gender  Male  Female (Check One)

Race \_\_\_\_\_

**PAST OCULAR HISTORY**

**PAST MEDICAL HISTORY**

**SURGICAL HISTORY**

For the following conditions please check (√):

- |   |  |  |
|---|--|--|
| <input type="radio"/> Cataract                      | <input type="radio"/> Diabetes                 | <input type="radio"/> Hepatitis            |
| <input type="radio"/> Glaucoma                      | <input type="radio"/> Hypertension             | <input type="radio"/> Migraines            |
| <input type="radio"/> Macular Degeneration          | <input type="radio"/> Coronary Artery Disease  | <input type="radio"/> Arthritis            |
| <input type="radio"/> Posterior Vitreous Detachment | <input type="radio"/> Heart Attack             | <input type="radio"/> Anemia               |
| <input type="radio"/> Retinal Hole                  | <input type="radio"/> Congestive Heart Failure | <input type="radio"/> Elevated Cholesterol |
| <input type="radio"/> Retinal Detachment            | <input type="radio"/> Arrhythmia               | <input type="radio"/> Lyme Disease         |
| <input type="radio"/> Strabismus (Crossed Eye)      | <input type="radio"/> Heart Blockage           | <input type="radio"/> Syphilis             |
| <input type="radio"/> Amblyopia (Lazy Eye)          | <input type="radio"/> Asthma                   | <input type="radio"/> Rosacea              |
| <input type="radio"/> Eye Infections                | <input type="radio"/> Emphysema/Bronchitis     | <input type="radio"/> Stroke               |
| <input type="radio"/> Dry Eye Syndrome              | <input type="radio"/> Tuberculosis             | <input type="radio"/> Herpes Simplex Virus |
| <input type="radio"/> Blepharitis                   | <input type="radio"/> Kidney Disease           | <input type="radio"/> Herpes Zoster Virus  |
| <input type="radio"/> Ptosis                        | <input type="radio"/> Liver Disease            | <input type="radio"/> Lupus                |
| <input type="radio"/> Blocked Tear Duct             | <input type="radio"/> Thyroid Disease          | <input type="radio"/> Sarcoidosis          |
| <input type="radio"/> Contact Lens Wearer           | <input type="radio"/> Seasonal Allergies       | <input type="radio"/> Multiple Sclerosis   |
|   | <input type="radio"/> HIV/AIDS                 | <input type="radio"/> Sjogren's Syndrome   |

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**PAST OCULAR SURGERIES**

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OCULAR MEDICATIONS**

**GENERAL MEDICATIONS**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENTLY NOT TAKING ANY MEDICATIONS

**DRUG ALLERGIES** For any of the following Drug Allergies please check (√):

- |                                    |   |   |  |                                     |
|------------------------------------|---|---|--|-------------------------------------|
| <input type="radio"/> Penicillin   | <input type="radio"/> Sulfa                   | <input type="radio"/> Iodine/Betadine/Shellfish | <input type="radio"/> Local Anesthetics/Novocain | <input type="radio"/> Adhesive Tape |
| <input type="radio"/> Other: _____ | <input type="radio"/> No Known Drug Allergies |   |  |                                     |

**SEE OTHER SIDE**

**SOCIAL HISTORY**

For the following please check (√):

**Alcohol Use:**    Never       Occasionally       Socially       Daily      **Smoking:**       Never       Former       Current  
**Occupation:** \_\_\_\_\_      **Travel Abroad:** \_\_\_\_\_

**FAMILY HISTORY**

Please indicate with a check (√) relatives with any of the following conditions:

- Family History Unknown
- No Significant Family History

	Mother	Father	Sibling	Child	Grandparent
Diabetes					
Hypertension					
Coronary Artery Disease					
Cataracts					
Macular Degeneration					
Retinal Disease					
Glaucoma					

**REVIEW OF SYSTEMS**

For the following please check (√):

**GENERAL HEALTH**

- Unexplained Fever
- Night Sweats
- Weight Loss

**CARDIOVASCULAR**

- Chest Pain
- Skipped Heart Beat
- Rapid Heart Beat

**ENDOCRINE**

- Heat or Cold Intolerance
- Sweating
- Excessive Thirst
- Yellow Eyes or Skin

**INTEGUMENTARY**

- Skin Rashes

**NEUROLOGICAL**

- Headaches
- Dizziness
- Weakness
- Blackouts
- Fainting
- Seizures
- Numbness
- Tingling
- Tremors
- Decreased Memory

**GENITOURINARY**

- Frequent Urination
- Burning During Urination
- Discharge

**RESPIRATORY**

- Wheezing
- Shortness of Breath
- Spitting up Blood
- Cough
- Painful Breathing
- COPD

**PSYCHIATRIC**

- Depression
- Anxiety
- Memory Loss
- Stress
- Hallucinations
- Bipolar
- ADHD

**GASTROINTESTINAL**

- Black Stool
- Abdominal Pain
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Excessive Gas
- Change in Bowel Habits
- Heartburn/Acid Reflux
- Rectal Bleeding
- Hiatal Hernia

**MUSCULOSKELETAL**

- Joint or Muscle Pain
- Morning Stiffness
- Back Pain
- Redness of Joints
- Swelling of Joints
- Gout

**EAR/NOSE/THROAT**

- Nosebleeds
- Earache
- Hearing Loss
- Ringing in Ears
- Trouble Swallowing
- Sore Throat
- Stuffiness
- Itching
- Discharge
- Hay Fever

**BLOOD/LYMPH**

- Easy Bruising

**IMMUNOLOGICAL**

- Sneezing
- Runny Nose
- Food Allergies