Patient Medical History Form

Patient Name:___________________________________ HEIGHT: _____ ft. _____ in. WEIGHT: ___________

Primary Care Physician: _____________________________________ Physician Phone: ____________________

Reason for today's visit: ____

Date of last eye exam:____________________ by Dr.____________________________ ☐ Local Dr ☐ out of state Dr

Please List your current Medications, including over the counter, herbals and supplements

Med ___________________________________ Dosage _______________________ For ________________________

Med ___________________________________ Dosage _______________________ For ________________________

Med ___________________________________ Dosage _______________________ For ________________________

Med ___________________________________ Dosage _______________________ For ________________________

Allergies ☐ No known allergies

Allergic to ☐ Shellfish ☐ Iodine ☐ Latex Reaction ____________________ ☐ mild ☐ moderate ☐ severe

Allergy to _________________________ Reaction ________________________ ☐ mild ☐ moderate ☐ severe

List Medical Surgeries

Date _____________ Procedure ________________________ Surgeon ___________________ Complications ___________

Date _____________ Procedure ________________________ Surgeon ___________________ Complications ___________

List Eye Surgeries

Date _____________ Procedure ________________________ Surgeon ___________________ Complications ___________

Date _____________ Procedure ________________________ Surgeon ___________________ Complications ___________

☐ **Check here if all items are "Negative"**

Endocrine

☐ Type 1 Diabetes - IDDM ☐ Pre-diabetic ☐ Hypoglycemia

☐ Type 2 Diabetes - NIDDM ☐ Adrenal Gland Disorders ☐ Hypothyroidism

☐ Gestational diabetes ☐ Diabetes - Diet Controlled ☐ Hyperthyroidism

Hematologic/ Lymphatic

☐ Anemia ☐ Enlarged Lymph Nodes ☐ Leukemia

☐ Blood Disorders ☐ Hemachromatosis ☐ Lyme Disease

☐ Hemophilia ☐ Lymphoma

Cardiovascular/ Heart

☐ Angina ☐ Cyanosis ☐ Irregular Heart Beat

☐ Arrhythmia ☐ Heart Disease ☐ Mitral Valve Prolapse

☐ Bypass Graft ☐ Heart Murmur ☐ Pacemaker

☐ Bypass Surgery ☐ Heart Palpitation ☐ Shortness Of Breath

- [ ] Chest Pain
- [ ] Congestive Heart Failure
- [ ] Coronary Artery Disease
- [ ] High Blood Pressure Controlled
- [ ] High Blood Pressure Uncontrolled
- [ ] High Cholesterol
- [ ] History Of Heart Disease
- [ ] Stent
- [ ] Stroke
- [ ] Valve Replacement

Neurological

- [ ] Bell's Palsy
- [ ] Cranial Nerve Palsy
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Involuntary Movement
- [ ] Migraines
- [ ] Paralysis
- [ ] Seizures
- [ ] Stroke
- [ ] TIA
- [ ] Vertigo

Ears, Nose, Throat

- [ ] Chronic Colds
- [ ] Chronic Sinusitis
- [ ] Chronic Strep Infections
- [ ] Dentures
- [ ] Ear - Itching
- [ ] Ear Infections
- [ ] Ear Pain
- [ ] Hearing Aid Both Ears
- [ ] Hearing Aid Left Ear
- [ ] Hearing Aid Right Ear
- [ ] Hearing Loss Left Ear
- [ ] Hearing Loss Right Ear
- [ ] Mouth Sores
- [ ] Nose Bleeds
- [ ] Partial Hearing Loss Both Ears
- [ ] Partial Hearing Loss Left Ear
- [ ] Partial Hearing Loss Right Ear
- [ ] Ringing In Ears
- [ ] Runny Nose
- [ ] Sinus Pain
- [ ] Sinusitis
- [ ] Sore Throat
- [ ] Stuffy Nose

Respiratory/ Lungs

- [ ] Asthma
- [ ] Bronchitis
- [ ] Chronic Bronchitis
- [ ] Chronic Cough
- [ ] Collapsed Lung Left
- [ ] Collapsed Lung Right
- [ ] COPD
- [ ] Cough
- [ ] Emphysema
- [ ] Lung Cancer
- [ ] Pleurisy
- [ ] Pneumonia
- [ ] Sarcoid
- [ ] Shortness Of Breath
- [ ] Tuberculosis

Stomach/ Intestines

- [ ] Abdominal Pain
- [ ] Bowel Cancer
- [ ] Change In Appetite
- [ ] Constipation
- [ ] Crohn's Disease
- [ ] Diarrhea
- [ ] Esophagitis
- [ ] Frequency Of Bowel Movements
- [ ] Gall Bladder Disease
- [ ] Gastric Reflux
- [ ] Heartburn
- [ ] Hemorrhoids
- [ ] Hernia
- [ ] Indigestion
- [ ] Irritable Bowel Syndrome
- [ ] Jaundice
- [ ] Nausea
- [ ] Pancreatitis

- [ ] Difficulty Swallowing
- [ ] Diverticulitis
- [ ] Hepatitis Type A
- [ ] Hepatitis Type B
- [ ] Hepatitis Type C
- [ ] Stomach Cancer
- [ ] Ulcerative Colitis
- [ ] Ulcers

Integumentary/ Skin

- [ ] Basal Cell Carcinoma
- [ ] Bruising
- [ ] Changes In Color/ Pigmentation
- [ ] Changes In Nails/ Hair
- [ ] Dermatitis
- [ ] Dryness
- [ ] Eczema
- [ ] Excessive Sweating
- [ ] Itching
- [ ] Lupus
- [ ] Psoriasis
- [ ] Skin Cancer
- [ ] Skin Rash

Bones/ Joints/ Muscles

- [ ] Arthritis
- [ ] Back Pain
- [ ] Bone Cancer
- [ ] Cerebral Palsy
- [ ] Gout
- [ ] Joint Pain
- [ ] Juvenile Rheumatoid Arthritis
- [ ] Limited Range Of Motion
- [ ] Multiple Sclerosis
- [ ] Muscle Pain
- [ ] Muscular Dystrophy
- [ ] Neck Pain
- [ ] Polymyalgia
- [ ] Rheumatoid Arthritis

Allergic/ Immunologic

- [ ] Allergy Shots
- [ ] HIV
- [ ] Lupus
- [ ] Immune Disorder

Psychiatric

- [ ] Depression
- [ ] Panic Episodes
- [ ] Stress

Genitals/ Kidney/ Bladder

- [ ] Bladder Infections
- [ ] Bladder Repair
- [ ] Bladder Spasms
- [ ] Cervical Cancer
- [ ] Changes In Color Of Urine
- [ ] Dialysis
- [ ] Endometriosis
- [ ] Frequent Urination
- [ ] Incontinence
- [ ] Kidney Failure
- [ ] Kidney Infections
- [ ] Kidney Stones
- [ ] Kidney Transplant
- [ ] Menopause Symptoms
- [ ] Ovarian Cancer
- [ ] Ovarian Cysts
- [ ] Prostate Cancer
- [ ] Recurrent Urinary Tract Infections
- [ ] Renal Cancer
- [ ] Renal Stricture
- [ ] Sexually Transmitted Disease
- [ ] Testicular Cancer
- [ ] Uterine Cancer
- [ ] Uterine Fibroids

Constitution

☐ Fatigue ☐ Fever ☐ Sudden Weight Gain / Loss ☐ Weakness

Other ______________________

Social History

Do you smoke? ☐ Yes – how much ___________ ☐ Former Smoker ☐ No ☐ Never Smoked

Do you drink alcohol? ☐ Yes – type____________ how much ______________ ☐ No

Recreational drug use? ☐ Yes – type____________ how much ______________ ☐ No

Occupation ____

Hobbies ____

Eye History	Date Diagnosed
Glaucoma	______________
Cataracts	______________
Macular Degen	______________
Eye Injury	______________
Retinal Disease	______________
Other Disease	______________
Blindness	______________
Strabismus	______________
Amblyopia	______________
Dry Eye	______________
Refractive	______________
Other___________	______________

Family History	Relationship
Glaucoma	_____________
Cataracts	_____________
Macular Degen	_____________
Retinal Disease	_____________
Other Disease	_____________
Blindness	_____________
Strabismus	_____________
Amblyopia	_____________
Diabetes	_____________
Cancer	_____________
Heart Disease	_____________
Hypertension	_____________
High Cholesterol	_____________
Kidney Disease	_____________
Stroke	_____________
Other____________	_____________

Patient Signature ____________________________________ Date _____ / _____ / ________