Patient Medical History

Name: _____ **DOB**: _____ **Date**: _____

Who may we thank for your referral? _____

What is the reason for your visit today (major problem)? _____
Which eye? □ Right □ Left □ Both
What are your other symptoms? □ pain □ flashes □ floaters □ curtain □ blurry vision, other: _____
How long have you had this? #___ days ___ weeks ___ months ___ years other: _____

Allergies: □ none _____

Current medications: □ none _____
_____

Vitamins/supplements: □ none _____

Who is your regular/general doctor? _____Phone: _____

Eye problems:□ cataract □ glaucoma
□ macular degeneration (AMD) □ diabetic retinopathy
□ blocked blood vessels (vein or artery) □ dry eye
□ retinal detachment □ other _____

Medical problems: □ high blood pressure □ cancer (type) _____
□ stroke □ diabetes # _____ years □ arthritis
□ anemia □ high cholesterol □ asthma □ depression
□ seasonal allergies □ thyroid □ low □ high □ blood clots □ anxiety
□ gout □ heart disease □ low □ high heart rate
□ emphysema □ HIV □ AIDS □ hepatitis □ other: _____

Do you smoke? □ yes □ no # packs a day? _____ Do you drink alcohol? □ yes □ no
Do you use street drugs? □ yes □ no Type? _____ Are you pregnant? □ yes □ no

Past eye surgeries: □ cataract surgery □ right □ left □ retina surgery □ rt □ left
□ glaucoma surgery □ right □ left □ LASIK □ right □ left

Past surgeries: □ none _____

Family history (please indicate relation to you in blanks):
□ eye problems □ early cataract □ glaucoma □ retinal detachment □ other _____
□ high blood pressure □ diabetes □ arthritis
□ high cholesterol □ asthma □ thyroid □ low □ high
□ blood clots □ heart disease □ low/high heart rate
□ cancer (type) _____ □ other: _____

(please complete back side)

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Patient Medical History

Review of Systems

Please mark all that you are **currently** experiencing.

General:
□ weight loss/gain
□ recent cold/flu
□ inability to exercise
□ other: _____

Head/Ears/Nose/Throat:
□ headaches
□ colds
□ flu
□ difficulty swallowing
□ hearing problems
□ other: _____

(**Female**):
□ pregnant
□ post-menopausal
□ hormone-replacement therapy
□ oral contraceptives
□ other: _____

Breast:
□ lumps
□ tenderness
□ discharge
□ swelling
□ other: _____

Heart:
□ chest pain
□ heart murmurs
□ irregular heartbeat
□ other: _____

Lungs:
□ asthma
□ difficulty breathing
□ cough
□ fever
□ night sweats
□ other: _____

Genitals/Urinary:
□ increased urination
□ difficulty with urination
□ kidney stones
□ incontinence
□ venereal disease
□ other: _____

Skin:
□ rash
□ itching
□ inc. pigmentation
□ changes in hair growth or loss
□ nail changes
□ other: _____

Gastrointestinal:
□ abdominal pain
□ jaundice
□ constipation
□ nausea/ vomiting
□ diarrhea
□ other: _____

Muscles/Skeleton:
□ pain
□ swelling
□ redness or heat of muscles or joints
□ limitation of motion
□ muscular weakness
□ other: _____

Neurologic/Psychiatric:
□ migraines
□ tremors
□ memory loss
□ anxiety
□ depression
□ strokes
□ numbness
□ tingling
□ other: _____

Allergic/Immunologic/ Endocrine:
□ skin rashes
□ hormone therapy
□ increased thirst
□ increased urination
□ heat/cold intolerance
□ other: _____

Blood:
□ anemia
□ bleeding tendency
□ blood clots
□ previous transfusions or reactions
□ other: _____

Other problems:
□ other: _____

□ **none of the above**

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