Patient Medical History

Eye History

Amblyopia (lazy eye)	( ) Yes ( ) No
Blepharitis	( ) Yes ( ) No
Blindness	( ) Yes ( ) No
Cataract(s)	( ) Yes ( ) No
Color Blindness	( ) Yes ( ) No
Diabetic Retinopathy	( ) Yes ( ) No
Dry Eye Syndrome	( ) Yes ( ) No
Eye Injuries	( ) Yes ( ) No
Glaucoma	( ) Yes ( ) No
Glaucoma Suspect	( ) Yes ( ) No
High Rick Medication	( ) Yes ( ) No
Macular Degeneration	( ) Yes ( ) No
PVD	( ) Yes ( ) No
Retinal Detachment	( ) Yes ( ) No
Strabismus (eye turn)	( ) Yes ( ) No

Surgery/Date/Doctor:

_____

_____

Other:

_____

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Family Eye History

		Relationship to Patient
Amblyopia (lazy eye)	( ) Yes ( ) No	_____
Blindness	( ) Yes ( ) No	_____
Cataract(s)	( ) Yes ( ) No	_____
Color Blindness	( ) Yes ( ) No	_____
Eye Tumors	( ) Yes ( ) No	_____
Glaucoma	( ) Yes ( ) No	_____
Glaucoma Suspect	( ) Yes ( ) No	_____
Macular Degeneration	( ) Yes ( ) No	_____
Retinal Detachment	( ) Yes ( ) No	_____
Strabismus (eye turn)	( ) Yes ( ) No	_____

Family Medical History

		Relationship to Patient
Arthritis	( ) Yes ( ) No	_____
Cancer	( ) Yes ( ) No	_____
Diabetes	( ) Yes ( ) No	_____
Heart Disease	( ) Yes ( ) No	_____
High Blood Pressure	( ) Yes ( ) No	_____
Kidney Disease	( ) Yes ( ) No	_____
Lupus	( ) Yes ( ) No	_____
Stroke	( ) Yes ( ) No	_____
Thyroid Disease	( ) Yes ( ) No	_____

Social History—General

Current Occupation_____ Years _____ Employer_____

Do you drink alcohol? ( ) No ( ) Occasional ( ) 1 per day ( ) 2-3 per day ( ) 4+ per day

Do you smoke? ( ) No ( ) Occasional ( ) 1/2 pack per day ( ) 1 pack per day ( ) 1+ pack per day

Past Smoker? ( ) Yes ( ) No When did you quit smoking? _____

Tobacco use cessation intervention, counseling? ( ) Yes ( ) No Do you engage in regular exercise? ( ) Yes ( ) No

Do you chew tobacco? ( ) Yes ( ) No Do you use nutritional supplements (vitamin, etc)? ( ) Yes ( ) No

Do you use illegal drugs? ( ) Yes ( ) No Marital Status:_____

Patient Signature:_____ Date:_____

Please continue to other side

Review of Systems—Detailed

Constitutional Symptoms

Fever ( ) Yes ( ) No
Fatigue ( ) Yes ( ) No
Developmental Delay ( ) Yes ( ) No
Trauma ( ) Yes ( ) No
Other _____

Ear, Nose, Throat, Mouth

Hearing Loss ( ) Yes ( ) No
Sinus Disorders ( ) Yes ( ) No
Other _____

Cardiovascular

Atrial Fibrillation ( ) Yes ( ) No
Heart Disease ( ) Yes ( ) No
Hypertension ( ) Yes ( ) No
Stroke/TIA ( ) Yes ( ) No
Vascular Disease ( ) Yes ( ) No
Other _____

Respiratory

Asthma ( ) Yes ( ) No
Emphysema/COPD ( ) Yes ( ) No
Shortness of Breath ( ) Yes ( ) No
Other _____

Gastrointestinal

Intestinal Conditions ( ) Yes ( ) No
Other_____

Urinary

Flomax Use ( ) Yes ( ) No
Kidney Disease ( ) Yes ( ) No
Urinary Conditions ( ) Yes ( ) No
Other _____

Musculoskeletal

Arthritis ( ) Yes ( ) No
Muscle/Joint/Back ( ) Yes ( ) No
Pain _____
Other

Integumentary Symptoms

Herpes ( ) Yes ( ) No
Rash/Itching ( ) Yes ( ) No
Rosacea ( ) Yes ( ) No
Shingles ( ) Yes ( ) No
Skin Cancer ( ) Yes ( ) No
Other _____

Neurological

Multiple Sclerosis ( ) Yes ( ) No
Headaches ( ) Yes ( ) No
Convulsions/Seizure ( ) Yes ( ) No
Epilepsy ( ) Yes ( ) No
Other _____

Psychiatric

Memory Loss ( ) Yes ( ) No
Depression ( ) Yes ( ) No
Other _____

Endocrine

Diabetes ( ) Yes ( ) No
Thyroid Disease ( ) Yes ( ) No
Other _____

Blood

Anemia ( ) Yes ( ) No
Cholesterol ( ) Yes ( ) No
Other _____

Allergic/Immunological

Seasonal Allergies ( ) Yes ( ) No
Lupus ( ) Yes ( ) No
Other _____

Drug Allergies: Reaction

_____ _____

_____ _____

_____ _____

Medications:

_____

_____

_____

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