

PATIENT MEDICAL INFORMATION

Date: _____

Name: _____ Nickname: _____ Date of Birth: _____

Race: _____ Allergies: _____ PCP: _____

Other Doctors/ Referred By: _____ Pharmacy: _____

PATIENT MEDICATION LIST (including over-the counter)

Medication/Drops	Dosage	Times per Day		Medication/Drops	Dosage	Times per Day

EYE HISTORY – Have you been diagnosed with any of the following?

- | | |
|--|--|
| <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Cataracts _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Corneal Disease _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Crossed Eyes/ Lazy Eye _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma _____</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Eye Injury _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Iritis/ Uveitis _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Retina Disease _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Eye Disorders _____</p> |
|--|--|

Cataract Surgery (Date of Surgery) Right: _____ Left: _____

Other Eye Surgeries: _____

OTHER MEDICAL HISTORY – Have you been diagnosed with any of the following?

- | | |
|---|---|
| <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes; ___ # of years? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Conditions _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Pulmonary (i.e. asthma/emphysema, etc) _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer _____</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Head or Spinal injuries _____</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal lipids/Cholesterol _____</p> <p><input type="checkbox"/> <input type="checkbox"/> (Women) Are you pregnant? _____</p> |
|---|---|

Other Medical Conditions and Surgeries (include date & type): _____

SOCIAL HISTORY

- | | |
|---|---|
| <p>Current Occupation: _____</p> <p>Do you drive? ___ Yes ___ No</p> <p>Visual difficulty when driving? ___ Yes ___ No _____</p> <p>Drink alcohol? ___ Yes ___ No If yes, describe: _____</p> | <p><input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p> <p>Use tobacco? ___ Yes ___ No If yes, amount? _____</p> <p>Have you had a blood transfusion? ___ Yes ___ No</p> <p>Recreational drugs? ___ Yes ___ No _____</p> |
|---|---|

FAMILY MEDICAL HISTORY – Do any blood relatives have any of the following? (describe relation to patient)

- | | |
|--|---|
| <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetic Retinopathy _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer _____</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Macular Degeneration _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease _____</p> |
|--|---|

Other Eye and Relevant Diseases: _____

PATIENT MEDICAL INFORMATION (Page 2)

Date: _____

Name: _____ Nickname: _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: Male / Female

Review of Systems

CONDITIONS:	Circle any and all conditions that apply to you <u>or</u> check none.	Check (if None)
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches	
EARS, NOSE, THROAT:	hard of hearing, ear ache, cough, dry mouth, sinus/allergy, hoarseness, vertigo	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker	
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD, emphysema, TB exposure	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD,	
GENITOURINARY:	painful/ frequent urination, impotence, yellow jaundice, kidney stones, blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
DERMATOLOGIC:	pimples, acne, warts, growths, rash, rosacea, melanoma	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	anxiety, depression,	
ENDOCRINE:	diabetes, hypothyroid, hyperthyroid, hormone, increased thirst , Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	bleeding, anemia, blood clots, problems related to blood transfusions,	
ALLERGIC/ IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, rheumatoid arthritis,	
CANCER:	breast, prostate, lung, skin, colon , other	
EYES:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration	