PATIENT MEDICAL HISTORY

Date _____/_____/2009

Name ____ Referred by: _____________________________________

Optometrist: ______________________________________ Primary Care Physician: ________________________________

For what problem are you seeing us today? ____

____

Review of Systems: Please Circle NO or YES: **If YES Please Explain:**

Diabetes	NO	YES	___________________________________
High Blood Pressure	NO	YES	___________________________________
Respiratory problems (asthma, shortness of breath, emphysema)	NO	YES	___________________________________
Cardiovascular problems (heart attack, irregular heart beat…)	NO	YES	___________________________________
Ear/Nose/Throat problems (hearing loss, sinus, sore throat)	NO	YES	___________________________________
Gastrointestinal problems (vomiting, diarrhea…)	NO	YES	___________________________________
Urinary problems (kidney failure, dialysis, blood in urine…)	NO	YES	___________________________________
Skin problems (rashes, skin cancer…)	NO	YES	___________________________________
Muscle / Bone /Joint problems (arthritis…)	NO	YES	___________________________________
Neurologic problems (stroke, headaches…)	NO	YES	___________________________________
Psychiatric problems (depression, anxiety…)	NO	YES	___________________________________

Any other Medical Problems not listed above?

NO YES If YES please explain ____

____

Prior Surgery: Have you ever had surgery (other than eye surgery)?

NO YES If YES, provide date and reason ____

____

Hospitalizations: Have you ever been hospitalized?

NO YES If YES, provide date and reason ____

____

Continued on reverse

Past Eye History: Have you ever had any of the following eye problems? **If YES Please Explain:**

Amblyopia (lazy eye or crossed eyes) NO YES ______________________________

Glaucoma (high eye pressure) NO YES ______________________________

Cataract NO YES ______________________________

Macular degeneration NO YES ______________________________

Retinal Detachment NO YES ______________________________

Traumatic eye injury NO YES ______________________________

Have you ever had Eye Surgery? IF YES please describe:

NO YES ______________________________

____

Allergies: Are you allergic to any medications? If YES please list medication and reaction:

NO YES ______________________________

____

Medications: Please list all medications, eye drops and dosage which you are currently using:

____

____

____

____

Family Medical History: Do any medical or eye diseases run in your family (i.e. Blindness, Macular Degeneration, Retinal Detachment, Glaucoma, Diabetes, High Blood Pressure, Cancer)?

NO YES If YES, please explain: ______________________________

Social History: Occupation: ______________ Marital status: Single / Married / Divorced / Widowed

Do you smoke? NO YES How long? _________, packs a day? ___________ Have you ever quit? ____________

Alcohol / Drug use NO YES Please describe: ______________________________

Please note: Your eye doctor will use this information to help with your eye examination and treatment. Please notify your primary care physician if he/she is not aware of any of the information provided. You are warned and cautioned against driving and participating in potentially dangerous activities.

Signature of patient: ______________________________ Reviewed __________________MD ________/________/2009