

# PATIENT MEDICAL HISTORY RECORD

PATIENT NAME (LAST, FIRST) \_\_\_\_\_ BIRTHDATE (MM/DD/YY) \_\_\_\_\_ GENDER: M F

What is the reason for your appointment today? \_\_\_\_\_  
\_\_\_\_\_

## Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)?  
Yes \_\_\_ No \_\_\_ If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_
2. Have you ever had any eye disease or injury (e.g. glaucoma, cataract, lazy eye, or retinal detachment)?  
Yes \_\_\_ No \_\_\_ If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_
3. Have you ever had surgery?  
Yes \_\_\_ No \_\_\_ If YES, please provide date and procedure: \_\_\_\_\_  
\_\_\_\_\_
4. Have you ever been hospitalized? If YES, please provide date and reason: \_\_\_\_\_  
\_\_\_\_\_
5. Do you take any medications for general health (including aspirin, vitamins and herbals)?  
Yes \_\_\_ No \_\_\_ If YES, please list: \_\_\_\_\_  
\_\_\_\_\_  
Do you take any eye medications (including drops, ointments and pills)?  
Yes \_\_\_ No \_\_\_ If YES, please list: \_\_\_\_\_  
\_\_\_\_\_
6. Do you have any drug or food allergies?  
Yes \_\_\_ No \_\_\_ If YES, please list: \_\_\_\_\_  
\_\_\_\_\_

## Review of Systems

	Yes	No	If YES, please explain:
Do you currently have any of the following problems?:			
Chronic fever, unexpected weight loss/gain, fatigue	___	___	_____
Ear/nose/throat problems (e.g. hearing loss, sinus, sore throat)	___	___	_____
Heart problems (e.g. chest pain, irregular heartbeat)	___	___	_____
Respiratory problems (e.g. shortness of breath, wheezing, cough)	___	___	_____
Gastrointestinal problems (e.g. heartburn, belly pain, diarrhea, nausea)	___	___	_____
Urinary problems (e.g. pain, frequent urination, blood in urine)	___	___	_____
Skin problems (e.g. rashes, dermatitis, excessive dryness and itching)	___	___	_____
Musculoskeletal problems (e.g. muscle aches, joint pain or swelling)	___	___	_____
Neurological problems (e.g. numbness, weakness, headaches)	___	___	_____
Psychiatric problems (e.g. depression, anxiety)	___	___	_____

## Family and Social History

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, glaucoma, cataract, macular degeneration)?  
Yes \_\_\_ No \_\_\_ If YES, please explain: \_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Yes \_\_\_ No \_\_\_ If YES, how much? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_ No \_\_\_ If YES, how much? \_\_\_\_\_

Any other medical issues not addressed above? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_

M.D. Signature \_\_\_\_\_

Date (MM/DD/YY) \_\_\_\_\_

