PATIENT MEDICAL HISTORY RECORD

____ Gender M F
PATIENT NAME (LAST, FIRST) BIRTHDATE (MM/DD/YY)

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

1. Have you ever been treated for any medical conditions (diabetes, high blood pressure, arthritis, pulmonary disease, bowel disorder, neurological disorder, rheumatologic disorder or malignancy etc.?) ❑Yes ❑No
   If YES, please explain:____

   ____

2. Have you ever had any eye disease or injury (glaucoma, cataract, lazy eye, or retinal detachment)? ❑Yes ❑No
   If YES, please explain:____

   ____

3. Have you ever had any surgery? ❑Yes ❑No If YES, please provide date and procedure:____

4. Have you ever been hospitalized? ❑Yes ❑No
   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:___________________________
   ____

7. Do you take any eye medications (including drops, ointments and pills)?
   ❑Yes ❑No If YES, please list:_________________________________

8. Do you have any drug or food allergies? ❑Yes ❑No
   If YES, please list:____

Review of Systems

Do you currently have any of the following:

Chronic fever, unexpected weight loss/gain, fatigue ❑ Yes ❑ No
Please explain ______________________________

Ear/nose/throat problems (hearing loss, sinus, sore throat) ❑ Yes ❑ No
Please explain ______________________________

Heart problems (chest pain, irregular heartbeat) ❑ Yes ❑ No
Please explain ______________________________

Respiratory problems (shortness of breath, wheezing, cough) ❑ Yes ❑ No

Please explain ________________________________

Gastrointestinal problems (heartburn, belly pain, diarrhea, nausea) ❑ Yes ❑ No Please explain
____

Urinary problems (pain, frequent urination, blood in urine) ❑ Yes ❑ No
Please explain ________________________________

Skin problems (rashes, dermatitis, excessive dryness and itching) ❑ Yes ❑ No Please explain
____

Musculoskeletal problems (muscle aches, joint pain or swelling) ❑ Yes ❑ No Please explain
____

Neurological problems (numbness, weakness, headaches) ❑ Yes ❑ No
Please explain ________________________________

Psychiatric problems (depression, anxiety, other) ❑ Yes ❑ No
Please explain ________________________________

Endocrine problems (diabetes, thyroid) ❑ Yes ❑ No
Please explain ________________________________

Blood Disorders (leukemia, other) ❑ Yes ❑ No
Please explain ________________________________

Family and Social History

Do any medical or eye diseases run in your family (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? ________________

Do take any recreational drugs? ❑Yes ❑No
If YES, list what and how often? ____

Any other medical issues not addressed above?
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____
____
____

________________________ ________________________ ________________
Patient Signature MD Signature Date