PATIENT MEDICAL HISTORY RECORD

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

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: _________________________________________________

6. Do you take any eye medications (including drops, ointments and pills)?  ☐ Yes  ☐ No  If YES, please list: _________________________________________________

7. 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?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Patient Signature ___________________________ MD Signature ________________________ Date ____________________