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 surgery?
   - [ ] Yes  [ ] No  If yes, please provide date(s) and procedure(s):________________________________________________________

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  If yes, please explain:
   __________________________________________________________

Ear/nose/throat problems (hearing loss, sinus, sore throat)  - [ ] Yes  [ ] No  If yes, please explain:
   __________________________________________________________

Heart problems (chest pain, irregular heartbeat)  - [ ] Yes  [ ] No  If yes, please explain:
   __________________________________________________________

Respiratory problems (shortness of breath, wheezing, cough)  - [ ] Yes  [ ] No  If yes, please explain:
   __________________________________________________________
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Gastrointestinal problems (heartburn, belly pain, diarrhea, nausea)  ☐ Yes ☐ No If yes, please explain:
______________________________________________________________________________________

Urinary problems (pain, frequent urination, blood in urine)  ☐ Yes ☐ No If yes, please explain:
______________________________________________________________________________________

Skin problems (rashes, dermatitis, excessive dryness and itching)  ☐ Yes ☐ No If yes, please explain:
______________________________________________________________________________________

Musculoskeletal problems (muscle aches, joint pain or swelling)  ☐ Yes ☐ No If yes, please explain:
______________________________________________________________________________________

Neurological problems (numbness, weakness, headaches)  ☐ Yes ☐ No If yes, please explain:
______________________________________________________________________________________

Psychiatric problems (depression, anxiety, other)  ☐ Yes ☐ No If yes, please explain:
______________________________________________________________________________________

Endocrine problems (diabetes, thyroid)  ☐ Yes ☐ No If yes, please explain:
______________________________________________________________________________________

Blood Disorders (leukemia, other)  ☐ Yes ☐ No If yes, 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 ___________________________ Date __________

MD Signature ___________________________ Date __________