CONSULTING OPHTHALMOLOGISTS, P.C.

499 Farmington Avenue, Suite 100
Farmington, Connecticut 06032

295 Western Boulevard
Glastonbury, Connecticut 06033

Office Phone: (860) 678-0202

www.consultingeye.com

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