

PATIENT MEDICAL HISTORY RECORD

PATIENT'S NAME _____ TODAY'S DATE _____ BIRTH DATE _____ AGE _____

WHAT IS THE REASON FOR YOUR VISIT TO OUR OFFICE? _____

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 (e.g. glaucoma, cataract, wandering or "lazy eye", retinal detachment)?
Yes No If YES, please explain: _____
3. Have you ever had any surgery:
Yes No If YES, please provide date and reason: _____
4. Have you ever been hospitalized:
Yes No If YES, please provide date and reason: _____
5. Do you take any medications:
Yes No If YES, please list: _____
Do you take any eye medications:
Yes No If YES, please explain: _____
6. Do you have any drug or food allergies:
Yes No If YES, please list: _____
7. Please circle if you have: Asthma, Diabetes, High Blood Pressure, Arthritis, Thyroid, or Immune System Diseases
8. Are you taking Flomax? YES NO

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 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ear/Nose/Throat problems (e.g. hearing loss, sinus problems, sore throat) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart problems (e.g. chest pain, irregular heartbeat) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Respiratory problems (e.g. shortness of breath, wheezing, coughing) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Abdominal Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Urinary problems (e.g. pain or discomfort, blood in urine) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Skin problems (e.g. rashes, excessive dryness) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Neurological problems (e.g. numbness, weakness, headaches, paralysis) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Psychiatric problems (e.g. depression, anxiety) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Family and Social History

Do any medical or eye disease run in your family: (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

Yes No If YES please explain _____

Do you smoke? If YES, how much? drink alcohol? If YES, how much?

PLEASE CIRCLE IF YOU USE: GLASSES CONTACT LENSES

PLEASE CIRCLE IF YOU ARE HERE FOR OF IF YOU ARE INTERESTED IN:

NEW GLASSES CONTACT LENSES CONSULT LASER VISION CORRECTION CONSULT

DOCTOR'S SIGNATURE _____ DATE _____