MEDICAL HISTORY

Patient Name_____ **Date of Birth**_____ **Date**_____

Patient Signature_____ **Gender** ○ **Male** ○ **Female** (Check One) **Race**_____

PAST OCULAR HISTORY

For the following conditions please check (√):

- ○ Cataract
- ○ Glaucoma
- ○ Macular Degeneration
- ○ Posterior Vitreous Detachment
- ○ Retinal Hole
- ○ Retinal Detachment
- ○ Strabismus (Crossed Eye)
- ○ Amblyopia (Lazy Eye)
- ○ Eye Infections
- ○ Dry Eye Syndrome
- ○ Blepharitis
- ○ Ptosis
- ○ Blocked Tear Duct
- ○ Contact Lens Wearer

PAST MEDICAL HISTORY

- ○ Diabetes
- ○ Hypertension
- ○ Coronary Artery Disease
- ○ Heart Attack
- ○ Congestive Heart Failure
- ○ Arrhythmia
- ○ Heart Blockage
- ○ Asthma
- ○ Emphysema/Bronchitis
- ○ Tuberculosis
- ○ Kidney Disease
- ○ Liver Disease
- ○ Thyroid Disease
- ○ Seasonal Allergies
- ○ HIV/AIDS
- ○ Hepatitis
- ○ Migraines
- ○ Arthritis
- ○ Anemia
- ○ Elevated Cholesterol
- ○ Lyme Disease
- ○ Syphilis
- ○ Rosacea
- ○ Stroke
- ○ Herpes Simplex Virus
- ○ Herpes Zoster Virus
- ○ Lupus
- ○ Sarcoidosis
- ○ Multiple Sclerosis
- ○ Sjogren's Syndrome

SURGICAL HISTORY

_____

PAST OCULAR SURGERIES

_____

OCULAR MEDICATIONS

_____

GENERAL MEDICATIONS

_____

○ **CURRENTLY NOT TAKING ANY MEDICATIONS**

DRUG ALLERGIES For any of the following Drug Allergies please check (√):

○ **Penicillin** ○ **Sulfa** ○ **Iodine/Betadine/Shellfish** ○ **Local Anesthetics/Novocain** ○ **Adhesive Tape**

○ **Other**:_____ ○ **No Known Drug Allergies**

SEE OTHER SIDE

SOCIAL HISTORY

For the following please check (√):

Alcohol Use: ○ Never ○ Occasionally ○ Socially ○ Daily **Smoking**: ○ Never ○ Former ○ Current

Occupation:_____ **Travel Abroad**: _____

FAMILY HISTORY

Please indicate with a check (√) relatives with any of the following conditions:

○Family History Unknown

○No Significant Family History

	Mother	Father	Sibling	Child	Grandparent
Diabetes					
Hypertension					
Coronary Artery Disease					
Cataracts					
Macular Degeneration					
Retinal Disease					
Glaucoma					

REVIEW OF SYSTEMS

For the following please check (√):

GENERAL HEALTH
- ○ Unexplained Fever
- ○ Night Sweats
- ○ Weight Loss

CARDIOVASCULAR
- ○ Chest Pain
- ○ Skipped Heart Beat
- ○ Rapid Heart Beat

ENDOCRINE
- ○ Heat or Cold Intolerance
- ○ Sweating
- ○ Excessive Thirst
- ○ Yellow Eyes or Skin

INTEGUMENTARY
- ○ Skin Rashes

NEUROLOGICAL
- ○ Headaches
- ○ Dizziness
- ○ Weakness
- ○ Blackouts
- ○ Fainting
- ○ Seizures
- ○ Numbness
- ○ Tingling
- ○Tremors
- ○ Decreased Memory

GENITOURINARY
- ○ Frequent Urination
- ○ Burning During Urination
- ○ Discharge

RESPIRATORY
- ○ Wheezing
- ○ Shortness of Breath
- ○ Spitting up Blood
- ○ Cough
- ○ Painful Breathing
- ○ COPD

PSYCHIATRIC
- ○ Depression
- ○ Anxiety
- ○ Memory Loss
- ○ Stress
- ○ Hallucinations
- ○ Bipolar
- ○ ADHD

GASTROINTESTINAL
- ○ Black Stool
- ○ Abdominal Pain
- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Excessive Gas
- ○ Change in Bowel Habits
- ○ Heartburn/Acid Reflux
- ○ Rectal Bleeding
- ○ Hiatal Hernia

MUSCULOSKELETAL
- ○ Joint or Muscle Pain
- ○ Morning Stiffness
- ○ Back Pain
- ○ Redness of Joints
- ○ Swelling of Joints
- ○ Gout

EAR/NOSE/THROAT
- ○ Nosebleeds
- ○ Earache
- ○ Hearing Loss
- ○ Ringing in Ears
- ○ Trouble Swallowing
- ○ Sore Throat
- ○ Stuffiness
- ○ Itching
- ○ Discharge
- ○ Hay Fever

BLOOD/LYMPH
- ○ Easy Bruising

IMMUNOLOGICAL
- ○ Sneezing
- ○ Runny Nose
- ○ Food Allergies