MEDICAL HISTORY

Name: _____DOB: _____ Date: _____

Please fill out all sections (front and back). If not applicable, write "none".

HEALTH HISTORY QUESTIONS

Arthritis/Rheumatoid	No Yes
Lung Disease (Asthma, Bronchitis, Emphysema, etc.)	No Yes
Kidney Disease	No Yes
Diabetes: Insulin or Non-Insulin Dependent?	No Yes
Temporal Arteritis	No Yes
Carotid Artery Disease	No Yes
Stroke	No Yes
Heart Disease	No Yes
High Blood Pressure	No Yes
Cholesterol Problems	No Yes
Stomach Problems (Ulcer, Heartburn, Acid Reflux, GERD, etc.)	No Yes
Migraines	No Yes
Head or Spinal Injuries	No Yes
Cancer	No Yes
Infectious/Communicable Disease (Hepatitis, Staph, MRSA, Shingles, TB, Herpes, HIV, AIDS, STD'S, etc.)	No Yes
Thyroid	No Yes
Are you pregnant or nursing?	No Yes

Other diagnosed health problems not mentioned above: _____

CURRENT MEDICATIONS/DOSAGE*

*If you have filled out a separate medication list, please disregard this section and bring the list with you.

_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES/SENSITIVITIES TO MEDICATIONS

_____
_____
_____
_____

Have you had a bad reaction to Anesthesia? No Yes Has a blood relative had a bad reaction to anesthesia? No Yes

OCULAR HISTORY

Cataract	No Yes
Macular Degeneration	No Yes
Glaucoma	No Yes
Lazy Eye	No Yes

Other: _____

PREVIOUS EYE SURGERIES

_____
_____
_____
_____

OTHER SURGERIES

_____
_____
_____
_____
_____

SOCIAL HISTORY

Smoking?	No Yes	Amount _____ Years _____
Drinking?	No Yes	Amount _____ Years _____
Caffeine?	No Yes	Amount per day _____
Recreational Drugs?	No Yes	Formerly _____
Live Alone?	No Yes	
Do you drive?	No Yes	

Occupation: _____

FAMILY HISTORY

		Who?
Diabetes	No Yes	_____
Heart Disease	No Yes	_____
Cancer	No Yes	_____
Stroke	No Yes	_____
Macular Degeneration	No Yes	_____
Cataracts	No Yes	_____
Glaucoma	No Yes	_____
Lazy Eye	No Yes	_____
Retinal Detachment	No Yes	_____
Blindness	No Yes	_____
Other: _____	No Yes	_____

See more on back

Patient History Update (office use only)

Date	Initials	Date	Initials	Date	Initials	Date	Initials	Date	Initials

REVIEW OF SYSTEMS

Please circle "Y" if you CURRENTLY have any of the following, or "N" if you do not.

Constitutional

- N Y Fatigue
- N Y Fever
- N Y Weakness
- N Y Weight Gain
- N Y Weight Loss

Cardiovascular

- N Y Arrhythmia
- N Y Chest pressure or Discomfort
- N Y Irregular Heartbeat
- N Y Leg Swelling
- N Y Tachycardia (rapid heartbeat)

Metabolic/Endocrine

- N Y Cold Intolerance
- N Y Heat Intolerance
- N Y Polydipsia (insatiable thirst)
- N Y Polyphagia (overeating)
- N Y Polyuria (frequent urination)

Integumentary

- N Y Dry Skin
- N Y Hives
- N Y Itching Skin
- N Y Rash

HEENT

- N Y Exophthalmos (bulging eyes)
- N Y Hearing Loss
- N Y Sinus Problems
- N Y Sore Throat
- N Y Tinnitus (ringing in ears)

Gastrointestinal

- N Y Abdominal Pain
- N Y Decreased Appetite
- N Y Heartburn
- N Y Nausea
- N Y Vomiting

Neurological

- N Y Balance Disturbances
- N Y Dizziness
- N Y Headache
- N Y Memory Difficulty
- N Y Numbness of Extremities

Musculoskeletal

- N Y Arthralgias (joint pain)
- N Y Back Pain
- N Y Joint Swelling
- N Y Muscle Weakness

Respiratory

- N Y Asthma
- N Y Cough
- N Y Dyspnea (breathing difficulty)

Genitourinary

- N Y Dysuria (painful urination)
- N Y Hematuria (blood in urine)
- N Y Irregular Menses

Psychiatric

- N Y Depressed Mood
- N Y Emotional Changes
- N Y Insomnia
- N Y Nervousness
- N Y Stress

Hematologic/Lymphatic

- N Y Bleeding
- N Y Bruising
- N Y Lymphadenopathy (enlarged nodes)

Immunologic

- N Y Food Allergies
- N Y Seasonal Allergies