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.

____
____
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____
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____
____
____

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