PATIENT MEDICAL HISTORY

NAME: _____

DRUG ALLERGIES: _____

PAST OCULAR SURGERIES: _____

CURRENT EYE MEDICATIONS: _____

PAST SURGERIES: _____

CURRENT MEDICATIONS: _____

FAMILY HISTORY (CIRCLE ALL THAT APPLY): DIABETES CATARACTS GLAUCOMA LAZY EYE MACULAR DEGENERATION

SMOKING STATUS (CIRCLE ONE): NEVER SMOKED CURRENT SOMEDAY SMOKER CURRENT EVERYDAY SMOKER FORMER SMOKER

ALCOHOL (CIRCLE ONE): YES NO DRUGS (CIRCLE ONE): YES NO

REVIEW OF SYSTEMS (PLEASE CIRCLE YES OR NO)

EYES			RESPIRATORY			BLOOD/LYMPH NODES		
Previous Surgery	Y	N	Cough	Y	N	Easy Bruising	Y	N
Contact Lens	Y	N	Congestion	Y	N	Gums Bleeding Easily	Y	N
Pain	Y	N	Wheezing	Y	N	Prolonged Bleeding	Y	N
Double Vision	Y	N	Asthma	Y	N	Heavy Aspirin Use	Y	N
Glaucoma	Y	N						
Cataracts	Y	N						
Macular Degeneration	Y	N	GASTROINTESTINAL			MUSCULOSKELETAL		
Dry Eyes	Y	N	Heartburn	Y	N	Stiffness	Y	N
Flashes	Y	N	Nausea/ Vomiting	Y	N	Arthritis	Y	N
Floaters	Y	N	Jaundice/Hepatitis	Y	N	Joint Pain/Swelling	Y	N
EAR, NOSE & THROAT			GENITO-URINARY			SKIN		
Hard of Hearing	Y	N	Pain/Difficulty	Y	N	Rash/Sores	Y	N
Ringing in Ears	Y	N	Blood in Urine	Y	N	Lesions	Y	N
Vertigo	Y	N	History of Kidney Stones	Y	N	Hives/Eczema	Y	N
			History of STD's	Y	N			
CARDIOVASCULAR			PSHYCHIATRIC			NEUROLOGICAL		
Chest Pain	Y	N	Anxiety/Depression	Y	N	Seizures	Y	N
Dizziness	Y	N	Mood Swings	Y	N	Weakness/Paralysis	Y	N
Fainting Spells	Y	N	Difficulty Sleeping	Y	N	Numbness	Y	N
Shortness of Breath	Y	N				Tremors	Y	N
Irregular Heart Beat	Y	N						
Difficulty Lying Flat	Y	N	ENDOCRINE			IMMUNOLOGIC		
			Increased Thirst	Y	N	Hives	Y	N
			Increased Hunger	Y	N	Itching	Y	N
CONSTITUTIONAL			Increased Urination	Y	N	Runny Nose	Y	N
Fatigue/Weakness	Y	N	Increased Sweating	Y	N	Sinus Pressure	Y	N
Fever	Y	N	Fingernail Changes	Y	N			
Weight Gain/Loss	Y	N						