

## Patient Medical History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

### EYE HISTORY:

Have you had any of the following:

Yes No

Diabetic Retinopathy

Yes No

Glaucoma

Macular Degeneration

Eye Injury

Eye Surgery or Laser? If yes, list below:

Approx. Date Type of Surgery

Operating Surgeon

Right Eye:

\_\_\_\_\_

Left Eye:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other major eye problems? \_\_\_\_\_

Present Eye Medications:  None

Artificial Tears

Zinc/Vitamins

List Others: \_\_\_\_\_

Have you visited the Low Vision Center?  Yes  No

What Low Vision Aids do you use? \_\_\_\_\_

### PAST MEDICAL HISTORY:

Do you have now have or have you had in the past:

Sleep Apnea?  Yes  No If yes, do you use a C-Pap Machine?  Yes  No

No

Yes No

Diabetes: \_\_\_\_\_ years

Yes No

Asthma

High Blood Pressure

Stroke

Heart Disease

Cancer: Type \_\_\_\_\_

List any other major illnesses or injuries you have had: \_\_\_\_\_

PAST SURGICAL HISTORY:  No Prior Surgery (List type of surgery and approximate date): \_\_\_\_\_

ALLERGIES TO MEDICATIONS:  None  Yes,

List: \_\_\_\_\_

PRESENT MEDICATIONS: Dose (For example, Dyazide: 25 mg/day) (include birth control and aspirin)

None

1. \_\_\_\_\_ : \_\_\_\_\_

2. \_\_\_\_\_ : \_\_\_\_\_

4. \_\_\_\_\_ : \_\_\_\_\_

5. \_\_\_\_\_ : \_\_\_\_\_

6. \_\_\_\_\_ : \_\_\_\_\_

3. \_\_\_\_\_: \_\_\_\_\_ 7. \_\_\_\_\_: \_\_\_\_\_

**FAMILY HISTORY:**

Have any of your blood relatives had:

| <u>Yes</u>               | <u>No</u>                | <u>Relationship to Patient</u>    |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Blindness</b> _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Macular Degeneration</b> _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Retinal Detachment</b> _____   |

**SOCIAL HISTORY:**

Current Occupation: \_\_\_\_\_

Do you use: Tobacco? \_\_\_\_\_ If yes, how much per day? \_\_\_\_\_  
Alcohol? \_\_\_\_\_ If yes, how much per day? \_\_\_\_\_

**REVIEW OF SYSTEMS:**

| <u>Yes</u>               | <u>No</u>                |  | <u>If Yes, Please Explain</u> |
|--------------------------|--------------------------|--|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Fever/chills/weight change</b>                      | _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Hoarseness/hearing or sinus problem</b>             | _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Chest pain/palpitations/heart problems</b>          | _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Shortness of breath/cough/lung problems</b>         | _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Digestive/intestine problems</b>                    | _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Kidney/bladder/genital problems</b>                 | _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Muscle/joint pain; Arthritis</b>                    | _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Weakness/numbness/seizures</b>                      | _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Depression/anxiety/emotional problems</b>           | _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Excessive thirst or urination; hormone problems</b> | _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Easy bruising/bleeding/swollen glands</b>           | _____                         |

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History Reviewed/Physician=s Signature: \_\_\_\_\_ M.D.