PATIENT MEDICAL HISTORY RECORD

Patient Name:_____ Date of Birth: _____/_____/_____
Sex: _____ Age: _____

Primary Doctor_____ Referred by: _____

Please answer the following questions about your current medical status and history.

Patient Medical History:

	Yes	No		Yes	No
Diabetes	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐
Heart Disease	☐	☐	Epilepsy	☐	☐
Thyroid Disease	☐	☐	Kidney Disease	☐	☐
Allergies	☐	☐	Arthritis	☐	☐
Frequent Headaches	☐	☐	Heart Attack	☐	☐
Migraines	☐	☐	Hearing Loss	☐	☐
Dizzy Spells	☐	☐	Ringing in Ears	☐	☐
Difficulty Breathing	☐	☐	Chronic Cough	☐	☐

Patient Eye History:

	Yes	No		Yes	No
Glaucoma	☐	☐	Dryness	☐	☐
Cataracts	☐	☐	Discharge	☐	☐
Muscle Problems	☐	☐	Irritation	☐	☐
Retinal Problems	☐	☐	Floaters	☐	☐
Surgery	☐	☐	Flashing Lights	☐	☐
Laser Surgery	☐	☐	Pain	☐	☐
Blurry Vision/Loss of Vision	☐	☐	Inflammation	☐	☐
Double vision	☐	☐	Other Problem	☐	☐

Family Eye History:

	Yes	No		Yes	No
Glaucoma	☐	☐	Eye Surgeries	☐	☐
Cataracts	☐	☐	Other Problem	☐	☐
Eye Muscle Problems	☐	☐			

Please list all vitamins and medications you are presently taking. (Example: Tylenol, Vitamins, etc.)

_____

_____

Please list all eye medications you are presently using. (Example: Drops, Scrubs, etc.)

_____

_____

PLEASE COMPLETE BOTH SIDES

Please list ALL food and drug allergies:

_____

_____

Systems Review:

Check the appropriate box if applicable: If YES, please explain:	**Yes**	**No**
Chronic fever, unexpected weight loss or gain, or fatigue	☐	☐
Ear/nose/throat problems (ex: hearing loss, sinus problems, sore throat)	☐	☐
Heart problems (ex: chest pain, irregular heart beat)	☐	☐
Respiratory Problems (ex: shortness of breath, wheezing, coughing)	☐	☐
Gastrointestinal Problems (ex: heartburn, abdominal pain, diarrhea, vomiting)	☐	☐
Urinary Problems (ex: pain or discomfort, blood in urine)	☐	☐
Skin Problems (ex: rashes, excessive dryness)	☐	☐
Musculoskeletal Problems (ex: muscle aches, joint pain, swollen joints)	☐	☐
Neurological Problems (ex: numbness, weakness, headaches, paralysis)	☐	☐
Psychiatric Problems (ex: depression, anxiety)	☐	☐

Family & Social History

Do any medical or eye disease run in your family?	**Yes**	**No**
(Diabetes, High Blood Pressure, Cancer, Glaucoma, Macular Degeneration)	☐	☐

If Yes, please explain:

_____

_____

Date of last eye exam: _____ Where:_____

Comments/Other Information:_____

_____

_____

_____ _____

Doctor's Signature Date