

Patient Medical History

Name: _____ Age: _____ Date: _____

EYE HISTORY:

Have you had any of the following:

Yes No

Yes No

Diabetic Retinopathy

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

Yes No

Yes No

Diabetes: _____ years

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. _____:	_____	4. _____:	_____
2. _____:	_____	5. _____:	_____
3. _____:	_____	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"/>	Blindness _____
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration _____
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment _____

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"/>	Fever/chills/weight change	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness/hearing or sinus problem	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/palpitations/heart problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath/cough/lung problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Digestive/intestine problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder/genital problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Muscle/joint pain; Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Weakness/numbness/seizures	_____
<input type="checkbox"/>	<input type="checkbox"/>	Depression/anxiety/emotional problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst or urination; hormone problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising/bleeding/swollen glands	_____

History Reviewed/Physician=s Signature: _____ M.D.