Patient Medical History

Name: ____________________________ **DOB**: _______________ **Date**: ______________

Who may we thank for your referral? ____

What is the reason for your visit today (major problem)? ___________________________
Which eye? □ Right □ Left □ Both
What are your other symptoms? □ pain □ flashes □ floaters □ curtain □ blurry vision, other: ___________________
How long have you had this? #___ days ___ weeks ___ months ___ years other: _______

Allergies: □ none ____

Current medications: □ none ____
____

Vitamins/supplements: □ none ____

Who is your regular/general doctor? _____________________Phone: _________________

Eye problems:

□ cataract	□ glaucoma
□ macular degeneration (AMD)	□ diabetic retinopathy
□ blocked blood vessels (vein or artery)	□ dry eye
□ retinal detachment	□ other _________________

Medical problems:	□ high blood pressure	□ cancer (type) _______________	
□ stroke	□ diabetes # _______ years	□ arthritis	
□ anemia	□ high cholesterol	□ asthma	□ depression
□ seasonal allergies	□ thyroid □ low □ high	□ blood clots	□ anxiety
□ gout	□ heart disease	□ low □ high heart rate	
□ emphysema	□ HIV □ AIDS □ hepatitis	□ other: ____________	

Do you smoke? □ yes □ no # packs a day? _______ Do you drink alcohol? □ yes □ no
Do you use street drugs? □ yes □ no Type? ______ Are you pregnant? □ yes □ no

Past eye surgeries:	□ cataract surgery □ right □ left	□ retina surgery □ rt □ left
	□ glaucoma surgery □ right □ left	□ LASIK □ right □ left

Past surgeries: □ none ____

Family history (please indicate relation to you in blanks):
□ eye problems □ early cataract □ glaucoma □ retinal detachment □ other ____________

□ high blood pressure	□ diabetes	□ arthritis
□ high cholesterol	□ asthma	□ thyroid □ low □ high
□ blood clots	□ heart disease	□ low/high heart rate
□ cancer (type) ______________		□ other: ________________________

(please complete back side)

Patient Medical History

Review of Systems

Please mark all that you are **currently** experiencing.

General:
☐ weight loss/gain
☐ recent cold/flu
☐ inability to exercise
☐ other: ___________

Head/Ears/Nose/Throat:
☐ headaches
☐ colds
☐ flu
☐ difficulty swallowing
☐ hearing problems
☐ other: ____________

(**Female**):
☐ pregnant
☐ post-menopausal
☐ hormone-replacement therapy
☐ oral contraceptives
☐ other: ____________

Breast:
☐ lumps
☐ tenderness
☐ discharge
☐ swelling
☐ other: ____________

Heart:
☐ chest pain
☐ heart murmurs
☐ irregular heartbeat
☐ other: ___________

Lungs:
☐ asthma
☐ difficulty breathing
☐ cough
☐ fever
☐ night sweats
☐ other: ____________

Genitals/Urinary:
☐ increased urination
☐ difficulty with urination
☐ kidney stones
☐ incontinence
☐ venereal disease
☐ other: ____________

Skin:
☐ rash
☐ itching
☐ inc. pigmentation
☐ changes in hair growth or loss
☐ nail changes
☐ other: ____________

Gastrointestinal:
☐ abdominal pain
☐ jaundice
☐ constipation
☐ nausea/vomiting
☐ diarrhea
☐ other: ___________

Muscles/Skeleton:
☐ pain
☐ swelling
☐ redness or heat of muscles or joints
☐ limitation of motion
☐ muscular weakness
☐ other: ____________

Neurologic/Psychiatric:
☐ migraines
☐ tremors
☐ memory loss
☐ anxiety
☐ depression
☐ strokes
☐ numbness
☐ tingling
☐ other: ____________

Allergic/Immunologic/Endocrine:
☐ skin rashes
☐ hormone therapy
☐ increased thirst
☐ increased urination
☐ heat/cold intolerance
☐ other: ____________

Blood:
☐ anemia
☐ bleeding tendency
☐ blood clots
☐ previous transfusions or reactions
☐ other: ___________

Other problems:
☐ other: ____________

☐ **none of the above**