

PATIENT MEDICAL HISTORY

NAME: _____

DATE: _____

OCULAR HISTORY

Please answer the following questions about your eye health:

Have you ever been had any **LASIK, RK, PRK** or other **REFRACTIVE SURGERY?** (List surgery below) YES NO

Have you ever been diagnosed with **CATARACTS** or had **CATARACT SURGERY?** (List surgery below) YES NO

Have you ever been diagnosed with **GLAUCOMA?** (List any eye drops you are taking below) YES NO

Have you ever been diagnosed with **MACULAR DEGENERATION (AMD)?** (If receiving injections list below) YES NO

Have you ever been diagnosed with **DRY EYE SYNDROME?** (List any eye drops you are taking below) YES NO

Have you ever been diagnosed with **DIABETES?** YES NO

If you are diabetic: Type I Type II Last blood sugar: _____ A1c: _____

Which doctor do you see for your diabetes? _____

Have you ever been diagnosed with **ANY OTHER EYE DISEASE or CONDITIONS?** YES NO

List other eye conditions: _____

List any eye surgeries, which eye, and approximately when you had the surgery (for eye injections, list most recent one):

List any eye drops you take and how many times per day / when you take them:

MEDICAL HISTORY

List any other surgeries you have had the date and approximately when you had the surgery:

List any other medications you are taking including vitamins and over the counter meds, and how often you take them:

Please use back side of page to list more medications or have the front desk make a copy of your medication list.

List any medications you are allergic to: _____

Have you had this year's flu vaccine? YES NO

Are you allergic to Latex? YES NO

Have you had the pneumonia vaccine? YES NO

Do you smoke or use tobacco? YES NO

Have you had the COVID-19 vaccine? YES NO

Do you drink alcohol? YES NO

If yes, list which one: _____

PATIENT MEDICAL HISTORY

REVIEW OF SYSTEMS

Please check the box for any of the below medical conditions you have or are taking medications for:

CARDIOVASCULAR

- A-Fib
- High Cholesterol
- Hypertension
(High Blood Pressure)
- Heart Stent
- Heart Valve Replacement
- Stroke
- Other: _____

CONSTITUTIONAL

- Dizziness
- Unexplained Weight Loss
- Other: _____

ENDOCRINE

- Crohn's
- Diabetes (see ocular history)
- Thyroid Disorder
- Hormonal Disorder
- Other: _____

GASTROINTESTINAL

- Acid-reflux
- Colon / Stomach Cancer
- Gastrointestinal Disorder
- Hepatitis
- Ulcer
- Other: _____

GENITOURINARY

- Prostate Cancer
- STI – Viral, Herpetic,
Chlamydia, Syphilis
- Other: _____

HEMATOLOGIC/LYMPHATIC

- Anemia
- Leukemia
- Temporal Arteritis
- Other: _____

IMMUNOLOGIC

- AIDS / HIV Positive
- Herpes Zoster / Shingles
- Sjogren's Syndrome
- Other: _____

INTEGUMENTARY (SKIN)

- Eczema
- Lupus
- Ocular Rosacea / Blepharitis
- Psoriasis
- Other: _____

MUSCULOSKELETAL

- Ankylosing Spondylitis
- Arthritis
- Rheumatoid Arthritis
- Muscular Dystrophy
- Osteoporosis
- Fibromyalgia
- Other: _____

NEUROLOGICAL

- Bell's Palsy
- Dyslexia
- Epilepsy
- Headaches
- Migraines
- Multiple Sclerosis
- Parkinson's Disease
- Other: _____

PSYCHIATRIC

- ADD / ADHD
- Alzheimer's Disease
- Anxiety Disorder
- Dementia
- Depression
- Learning / Development
Disorder
- Schizophrenia
- Other: _____

RESPIRATORY

- Asthma
- Bronchitis
- COPD
- Emphysema
- Lung Cancer
- Pneumonia
- Other: _____

FAMILY HISTORY

Please check the box for any of the below medical conditions that any BLOOD RELATIVES in your family have had, and list the relation of the relative who had the condition (example: father, aunt, maternal grandmother, etc.):

- | | |
|--|--|
| <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Glaucoma: _____ |
| <input type="checkbox"/> High Blood Pressure: _____ | <input type="checkbox"/> Macular Degeneration: _____ |
| <input type="checkbox"/> High Cholesterol: _____ | <input type="checkbox"/> Retinal Detachment: _____ |
| <input type="checkbox"/> Amblyopia (Lazy Eye): _____ | <input type="checkbox"/> Other Eye Disease (List condition): _____ |
| <input type="checkbox"/> Blindness: _____ | _____ |
| <input type="checkbox"/> Cataract: _____ | _____ |