THE Eye Center

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Patient Medical History Form

Please read and complete each section carefully. Questions? Please ask a friendly and helpful member of our staff.

PATIENT INFORMATION

Name:_____ Date of Birth:_____ Age:_____

Primary Care Physician:_____

Please list ALL current medications and dosages:

_____
_____
_____
_____
_____
_____
_____
_____

Please list ANY drug reactions and/or allergies:

☐ NONE KNOWN

_____
_____
_____
_____
_____

Latex Allergy: YES NO
Pacemaker: YES NO
Defibrillator: YES NO
Sleep Apnea: YES NO
Aspirin: YES NO

MEDICAL HISTORY *(check and circle all that apply)*

- ☐ NONE
- ☐ Allergies?_____
- ☐ Cancer?_____
- ☐ Cardiovascular? High BP Chest Pain CHF Irregular Heartbeat High Cholesterol Pacemaker Defibrillator Valve Problems
- ☐ Endocrine? Diabetes Thyroid Imbalance
- ☐ Kidney Disease? Blood in Urine Pain on Urination Renal Failure
- ☐ Gastrointestinal?_____
- ☐ Musculoskeletal? Arthritis Lupus Joint Pain Muscle Aches Blood Clots
- ☐ Neurological? Stroke Weakness Numbness Dizziness Seizures
- ☐ Respiratory Disease? Asthma COPD SOB Wheezing Cough
- ☐ Surgical History_____

EYE HISTORY *(check and circle all that apply)*

- ☐ NONE
- ☐ Cataracts
- ☐ Crossed Eye(s)
- ☐ Diabetic Eye Disease
- ☐ Double/Blurred
- ☐ Dry Eye(s)
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Eye Pain
- ☐ Glaucoma
- ☐
- ☐
- ☐
- ☐ Halos/Flashes/Floaters
- ☐ Headaches
- ☐ Loss of Vision
- ☐ Macular Degeneration
- ☐ Retina Problems
- ☐ Other_____

TODAY'S COMPLAINTS *(Please use this space to indicate any ocular issues or reason for your visit)*

_____
_____
_____

FAMILY MEDICAL HISTORY *(Check and circle all that apply AND write the family member over the space provided_____)*

- ☐ Cancer_____ _____
- ☐ Cardiovascular High BP Chest Pain CHF Irregular Heartbeat High Cholesterol Pacemaker Defibrillator Valve Problems _____
- ☐ Endocrine Diabetes Thyroid Imbalance _____
- ☐ Neurological Stroke Weakness Numbness Dizziness Seizures _____
- ☐ Respiratory Disease Asthma COPD SOB Wheezing Cough

- ☐ Cataracts _____
- ☐ Diabetic Eye Disease _____
- ☐ Glaucoma _____
- ☐ Loss of Vision _____
- ☐ Macular Degeneration _____
- ☐ Retina Problems _____

SOCIAL HISTORY

Smoker? _____ _____ If YES, amount _____ per day. Alcohol Use? _____ _____ If YES, amount _____ per week.
YES NO YES NO

Pharmacy Name:_____ Address:_____ Telephone No.:_____ Fax No.:_____

Patient Signature:_____ Date:_____ Physician Signature:_____ Date:_____