



ROBERT C. FEINDMAN, MD, PA  
 SHANNEN K. ALLEN, MD  
 TERRY Y. KWAK, MD  
 NANCY J. SURIG, MD

ROCKVILLE PIKE  
 1801 Rockville Pike, #103  
 Rockville, MD 20852  
 240-221-3134 Fax

301-279-9696  
 www.theeyecenterinc.com

SHADY GROVE  
 15005 Shady Grove Rd., #100  
 Rockville, MD 20850  
 301-251-5454 Fax

**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: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_  
 Please list ALL current medications and dosages:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

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
- Halos/Flashes/Floaters
- Cataracts
- Headaches
- Crossed Eye(s)
- Loss of Vision
- Diabetic Eye Disease
- Macular Degeneration
- Double/Blurred
- Retina Problems
- Dry Eye(s)
- Other \_\_\_\_\_
- Eye Infection
- Eye Injury
- Eye Pain
- Glaucoma
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**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 \_\_\_\_\_)**

- |   |   |
|---|---|
| <input type="checkbox"/> Cancer _____   | <input type="checkbox"/> Cataracts _____            |
| <input type="checkbox"/> Cardiovascular High BP Chest Pain CHF Irregular Heartbeat<br>High Cholesterol Pacemaker Defibrillator Valve Problems | <input type="checkbox"/> Diabetic Eye Disease _____ |
| <input type="checkbox"/> Endocrine Diabetes Thyroid Imbalance   | <input type="checkbox"/> Glaucoma _____             |
| <input type="checkbox"/> Neurological Stroke Weakness Numbness Dizziness Seizures   | <input type="checkbox"/> Loss of Vision _____       |
| <input type="checkbox"/> Respiratory Disease Asthma COPD SOB Wheezing Cough   | <input type="checkbox"/> Macular Degeneration _____ |
|   | <input type="checkbox"/> 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: \_\_\_\_\_