THE Eye Center

ROCKVILLE PIKE
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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

_____ **Later 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 Unrination Remal 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 HISTIORY *(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
- ☐ Mascular Degeneration
- ☐ Retina Problems
- ☐ Other_____

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

_____

_____

_____

FAMILY MEDICAL HISTORY *(Check and cirlce 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 SOS Wheezing Cough

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

SOCIAL HISTORY

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

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

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