Patient Medical History Form

Your Name:_____ **Date of Birth:**_____

Allergies and bad reactions to medications:_____

_____

Medications: *List all medications currently taking, including eye drops.*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Patient Medical History: *Please check all that apply*

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ ADHD
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer-specify:_____
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes type I
- ☐ Diabetes type II
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ STD
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Hospitalized in the last month
- ☐ Other:_____

Past Surgical History: *List all surgeries and dates. Please also include any eye surgeries.*

Type of surgery:	Date(s):
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Social History:

Do you smoke? ____No ____Yes If yes, how many packs per day?_____

If you have quit, how long ago?_____

Do you use alcohol? ____No ____Yes If yes, how often do you drink?_____

Occupation: _____ If retired, last job title: _____

Last Medical Exam: _____ Last Eye Exam: _____

Medical Doctor(s): _____ Eye Doctor: _____

Living Conditions: ____Alone ____Family ____Caregiver ____Assisted living ____Nursing home

Preferred Language: _____ Ethnicity: Hispanic Non-Hispanic

Race: African-American Caucasian PacificIslander Other: _____

For Diabetics:

Age diagnosed: _____ Dialysis: ____No ____Yes If yes, what days:_____

Blood sugar level: _____ Date taken: _____

HA1c: _____ Date taken: _____

For Females:

Are you pregnant? _____No _____Yes If yes, how many weeks? _____

Are you nursing? _____No _____Yes

Family Medical History:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Conditions	Family Member						
	father	mother	brother	sister	son	daughter	other
Retinal Detachment							
Macular Degeneration							
Glaucoma							
Blindness							
Stroke							
Heart disease							
Diabetes							
High blood pressure							
High cholesterol							
Thyroid Disease							
Cancer-specify:							
Cancer-specify:							
Other:							
Other:							

Review of Systems: *Check all that apply*

Constitutional
- ☐ Fever
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Runny nose

HENT
- ☐ Hearing loss
- ☐ Sore throat
- ☐ Runny nose
- ☐ Dry mouth
- ☐ Ear Ache
- ☐ Has a cold
- ☐ Stuffy nose

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swelling of the feet
- ☐ Shortness of breath while laying flat
- ☐ Irregular heart beat
- ☐ Racing Pulse

Respiratory
- ☐ Wheezing
- ☐ Cough

Gastrointestinal
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gastrointestinal Ulcers

Endocrine
- ☐ Excess thirst
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Cold intolerance

Genitourinary
- ☐ Pain/burning on urination
- ☐ Blood in urine

Integumentary
- ☐ Rash
- ☐ Change in mole

Musculoskeletal
- ☐ Muscle aches
- ☐ Joint pain
- ☐ Paralysis of extremities
- ☐ Difficult laying flat due to musculoskeletal discomfort

Neurologic
- ☐ Weakness
- ☐ Headaches
- ☐ Scalp tenderness
- ☐ Paralysis of extremities
- ☐ Numbness and tingling

Hematology
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Anemia
- ☐ Swollen Lymph Nodes

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