

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

**Patient Medical History:** Please check all that apply

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

**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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