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MEDICAL HISTORY

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

Address: _____

Cell Phone: _____ **Home Phone:** _____

Emergency Contact/Phone: _____

Alternate Contact/Phone: _____

Do you have an Advance Directive? ☐ YES ☐ NO

PAST MEDICAL HISTORY: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH – Prostate Enlargement
- ☐ CVA - Stroke
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Other _____
- ☐ Diabetes
  - A1C _____
  - Fasting Blood Sugar _____
  - When Diagnosed? _____
- ☐ Kidney Disease
- ☐ Epilepsy/Seizures
- ☐ GERD-Reflux/Heartburn
- ☐ High Blood Pressure
- ☐ Hearing Loss
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Bone Marrow Trans
- ☐ NONE

PAST SURGICAL HISTORY: (please check all that apply and circle **L = LEFT R = RIGHT**)

- ☐ Appendix Surgery
- ☐ Colon Surgery/Removal
- ☐ Defibrillator
- ☐ Gall Bladder Surg/Removal
- ☐ Heart Artery Bypass
- ☐ Heart Balloon/Stent
- ☐ Heart Transplant
- ☐ Heart Valve Surgery
- ☐ Other _____
- ☐ Hip Replacement L R
- ☐ HIV/AIDS
- ☐ Hysterectomy-Uterus Surg
- ☐ Kidney Biopsy
- ☐ Knee Replacement
- ☐ Liver Surgery L R
- ☐ Liver Transplant
- ☐ Leukemia
- ☐ Lumpectomy L R
- ☐ Mastectomy L R
- ☐ Pacemaker
- ☐ Prostate Biopsy
- ☐ Prostate Reduction
- ☐ Prostate Removal
- ☐ Tonsillectomy
- ☐ NONE

PAST EYE HISTORY: (please check all that apply and circle **L = LEFT EYE R = RIGHT EYE**)

- ☐ Contact Lenses L R
- ☐ Allergic Conjunctivitis L R
- ☐ Narrow Angles L R
- ☐ Blepharitis L R
- ☐ Cataract L R
- ☐ Corneal Dystrophy L R
- ☐ Macular Degeneration L R
- ☐ Dry Eyes L R
- ☐ Other _____
- ☐ Macular Pucker/ERM L R
- ☐ Fuchs Dystrophy L R
- ☐ Glaucoma L R
- ☐ "Lazy" Eye L R
- ☐ Retinal Detachment L R
- ☐ Eye Injury L R
- ☐ Diabetic Retinopathy L R
- ☐ Ocular Migraine L R
- ☐ Retinal Tear L R
- ☐ "Crossed" Eyes L R
- ☐ Floaters L R
- ☐ Glasses
- ☐ Other _____ L R
- ☐ Other _____ L R
- ☐ NONE

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PAST EYE SURGERY: (please check all that apply, circle **L = LEFT EYE** **R = RIGHT EYE** and add the **YEAR**)

			Year				Year				Year
☐ Cataract Surgery	L	R	____	☐ Glaucoma Laser SLT	L	R	____	☐ Retina Detach Repair	L	R	____
☐ Corneal Crosslinking	L	R	____	☐ Glaucoma Trab	L	R	____	☐ Retina Laser	L	R	____
☐ Corneal Dystrophy	L	R	____	☐ Glaucoma Tube	L	R	____	☐ Retina Injection	L	R	____
☐ Corneal Transplant	L	R	____	☐ Goniotomy	L	R	____	☐ Vitrectomy Surg	L	R	____
☐ DESK Cornea Trnspl	L	R	____	☐ LASIK/PRK	L	R	____	☐ YAG Cap	L	R	____
☐ Eyelid Surgery	L	R	____	☐ Macular Hole Surg	L	R	____	☐ NONE			
☐ Glaucoma Laser PI	L	R	____	☐ Pterygium	L	R	____				

☐ Other _____

PHARMACY INFO:

Name: _____

Phone: _____

Street/City: _____

PRIMARY CARE DOCTOR:

Name: _____

Phone: _____

Street/City: _____

MEDICATIONS: (Please list all current **medications, strength** and **dose frequency**, *e.g. Lisinopril, 1 tablet, 10 mg daily*)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATION ALLERGIES: (Please list all allergies and your reaction)

_____ _____ _____ _____

_____ _____ _____ _____

SOCIAL HISTORY: (Please check all that apply)

CIGARETTE SMOKING

☐ Never smoked

☐ Smokes daily

☐ Former smoker

Packs per day _____

Total years of smoking _____

ALCOHOL

☐ Do not drink at all

☐ Less than 1 drink/day

☐ 1-2 drinks/day

☐ More than 3 drinks/day

DRIVING STATUS

☐ Daytime Driving

☐ Night Driving

OCCUPATION _____

FAMILY HISTORY: (Please check all that apply and circle the family member)

☐ Blindness	M	F	S	B	A	U	GM	GF
☐ Cancer	M	F	S	B	A	U	GM	GF
☐ Cataracts	M	F	S	B	A	U	GM	GF
☐ Corneal Dystrophy	M	F	S	B	A	U	GM	GF
☐ Diabetes	M	F	S	B	A	U	GM	GF
☐ Glaucoma	M	F	S	B	A	U	GM	GF
☐ Heart Disease	M	F	S	B	A	U	GM	GF
☐ Retinal Detachment	M	F	S	B	A	U	GM	GF
☐ Stroke	M	F	S	B	A	U	GM	GF
☐ Other	M	F	S	B	A	U	GM	GF

M = Mother
F = Father
S = Sister
B = Brother
A = Aunt
U = Uncle
GM = Grandmother
GF = Grandfather

ALERTS: Do you have any of the following? (Check if YES)

ALERT	OTHER
☐ Allergy to adhesive	
☐ Allergy to lidocaine	
☐ Allergy to Fluorescein	
☐ Allergy to Dilation Drops	
☐ Artificial Heart Valve	
☐ Artificial joints within past two years	
☐ Blood Thinners	
☐ Defibrillator	
☐ Flomax	
☐ MRSA	
☐ Narrow Angles	
☐ Pacemaker	
☐ Pregnancy or planning a pregnancy	
☐ Premedication prior to procedures	
☐ Rapid heartbeat with epinephrine	
☐ Steroid responder – Eye Pressure	

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Check if YES)

☐ Poor Vision	☐ Constipation	☐ OTHER
☐ Eye Pain	☐ Burning with Urination	
☐ Tearing	☐ Urinary Frequency	
☐ Red Eyes	☐ Incontinence	
☐ Jaw Pain	☐ Joint Pain	
☐ Scalp Tenderness	☐ Joint Stiffness	
☐ Amaurosis Fugax	☐ Arthritis	
☐ Loss of Vision	☐ Rash	
☐ Fever	☐ Changing Moles	
☐ Chills	☐ Headache	
☐ Unintentional Weight Loss	☐ Seizure	
☐ Stuffy Nose	☐ Stroke	
☐ Ear Ache	☐ Paralysis	
☐ Cough	☐ Anxiety	
☐ Dry Mouth	☐ Depression	
☐ High Blood Pressure	☐ Insomnia	
☐ Rapid Heart Beat	☐ Diabetes	
☐ Congestion	☐ Thyroid Problems	
☐ Wheezing	☐ Bleeding	
☐ Shortness of Breath	☐ Anemia	
☐ Upset Stomach	☐ Allergies	
☐ Diarrhea	☐ Hay Fever	
	☐ Hives	