Patient Medical History

NAME: ________________________________

Past Medical History:

Anxiety	Yes	No
Arthritis	Yes	No
Asthma	Yes	No
Irregular Heartbeat	Yes	No
Bone Marrow Transplant	Yes	No
BPH	Yes	No
Breast Cancer	Yes	No
Colon Cancer	Yes	No
COPD	Yes	No
Coronary Artery Disease	Yes	No
Depression	Yes	No
Diabetes	Yes	No
End Stage Renal Disease	Yes	No
GERD	Yes	No
Hearing Loss	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
HIV/AIDS	Yes	No
High Cholesterol	Yes	No
Hyper/Hypo Thryroidism	Yes	No
Leukemia	Yes	No
Lung Cancer	Yes	No
Lymphoma	Yes	No
Prostate Cancer	Yes	No
Radiation Treatment	Yes	No
Seizures	Yes	No
Stroke	Yes	No

Other:____________________________________

____

Past Surgical History:

Appendix	Yes	No
Bladder	Yes	No
Breast: Mastecomy	Yes	No
Breast: Lumpectomy	Yes	No
Breast Biopsy	Yes	No
Breast: Reduction	Yes	No
Breast: Implants	Yes	No
Colon Cancer Resection	Yes	No
Colon: Diverticulitis	Yes	No
Colon: Inflammatory Bowel	Yes	No
Gallbladder	Yes	No
Heart: Coronary Artery Bypass	Yes	No
Heart: PTCA	Yes	No
Heart: Mechanical Valve	Yes	No
Heart: Biological Valve	Yes	No
Heart: Transplant	Yes	No
Joint Replacement: Knee	Yes	No
Joint Replacement: Hip	Yes	No
Kidney: Biopsy	Yes	No
Kidney: Nephrectomy	Yes	No
Kidney: Stone Removal	Yes	No
Kidney: Transplant	Yes	No
Ovaries: Endometriosis	Yes	No
Ovarian Cyst	Yes	No
Ovarian Cancer	Yes	No
Prostate Cancer	Yes	No
Prostate Biopsy	Yes	No
Prostate: TURP	Yes	No
Skin: Biopsy	Yes	No
Skins: Basal Cell Carcinoma	Yes	No
Skin: Squamous Cell Carcinoma	Yes	No
Skin: Melanoma	Yes	No
Spleenectomy	Yes	No
Testicles: Orchiectomy	Yes	No
Uterus: Hysterectomy		
Fibroids	Yes	No
Uterine Cancer	Yes	No

Other:____________________________________

____

Ocular History:

Allergic Conjunctivitis	Yes	No
Blepharitis	Yes	No
Cataracts	Yes	No
Contact Lenses	Yes	No
Corneal Dystrophy	Yes	No
Diabetic Retinopathy	Yes	No
Dry Eyes	Yes	No
Glasses	Yes	No
Glaucoma	Yes	No
Macular Degeneration	Yes	No
Macular ERM	Yes	No
Narrow Angles	Yes	No
Ocular Hypertension	Yes	No
Ophthalmic Migraine	Yes	No
Pseudoexfoliation	Yes	No
Retinal Tear	Yes	No
Strabismus	Yes	No
PVD	Yes	No
Floaters	Yes	No

Other:____________________________________

Past Ocular Surgeries:

Blepharoplasty	Yes	No
Cataract Surgery	Yes	No
Corneal Transplant	Yes	No
DSAEK	Yes	No
Eye Muscle Surgery	Yes	No
Intravitreal Injection	Yes	No
LASIK	Yes	No
LPI	Yes	No
LTP	Yes	No
PRK	Yes	No
Ptosis Repair	Yes	No
Punctal Plugs	Yes	No
Strabismus Surgery	Yes	No
Retinal Laser	Yes	No
Trabeculoplastomy	Yes	No
Tube Shunt	Yes	No
YAG Capsulotomy	Yes	No

Other:___________________________________

Family History

Blindness	Yes	No
Cancer	Yes	No
Cataracts	Yes	No
CVA	Yes	No
Diabetes	Yes	No
Glaucoma	Yes	No
Heart Disease	Yes	No
Hypertension	Yes	No
Macular Degeneration	Yes	No
Migraine	Yes	No
Retinal Detachment	Yes	No
Strabismus	Yes	No

Other:___________________________________

Current Medications:

____
____
____
____
____
____
____

Allergies to Medications:

____
____
____

Review of Systems:

Have you recently had any of the following?

Poor Vision	Yes	No
Eye Pain	Yes	No
Tearing	Yes	No
Redness	Yes	No
Jaw Pain	Yes	No
Scalp Tenderness	Yes	No
Amaurosis Fugax	Yes	No
Loss of Vison	Yes	No
Fever	Yes	No
Chills	Yes	No
Weight Loss	Yes	No
Ear Ache	Yes	No
Cough	Yes	No
Dry Mouth	Yes	No
High Blood Pressure	Yes	No
Rapid Heart Beat	Yes	No
Shortness of Breath	Yes	No
Upset Stomach	Yes	No
Burning on Urination	Yes	No
Joint Pain	Yes	No
Rheumatoid Arthritis	Yes	No
Rash	Yes	No
Headache	Yes	No
Seizure	Yes	No
Stroke	Yes	No
Paralysis	Yes	No
Anxiety	Yes	No
Diabetes	Yes	No
Thyroid Abnormalities	Yes	No
Bleeding	Yes	No
Anemia	Yes	No
Allergies	Yes	No

Social History:

Smoking	Yes	No	Former
Alcohol		Yes	No
Caffeine		Yes	No
Drugs		Yes	No
Do you drive		Yes	No

Occupation:______________________________