# MEDICAL HISTORY

*Must be completed by patient every 3 years*

**PATIENT NAME:** _____

**DATE OF BIRTH:** _____ **TODAY'S DATE**_____

**REVIEW OF SYSTEMS**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Diabetes _____ # of yrs _____ | ☐ | ☐ | Hepatitis _____ |
| ☐ | ☐ | High Blood Pressure _____ # of yrs _____ | ☐ | ☐ | HIV/AIDS _____ |
| ☐ | ☐ | Heart Disease _____ | ☐ | ☐ | Arthritis (osteo/rheumatoid) _____ |
| ☐ | ☐ | Kidney Disease _____ | ☐ | ☐ | Autoimmune Disease ☐ Lupus ☐ Chohn's ☐ MS |
| ☐ | ☐ | Neurological Disease _____ | | | ☐ Fibromyalgia ☐ Chronic Fatigue Syn. ☐ Other |
| ☐ | ☐ | Carotid Artery Disease _____ | ☐ | ☐ | Migraines _____ |
| ☐ | ☐ | Stroke _____ | ☐ | ☐ | Head or Spinal Injuries _____ |
| ☐ | ☐ | Cancer _____ | ☐ | ☐ | Seizure, Convulsions or Fainting _____ |
| ☐ | ☐ | Thyroid Disease? _____ | ☐ | ☐ | (Women) Are you Pregnant or Nursing? _____ |
| ☐ | ☐ | Gastrointestinal Disease – Type _____ | ☐ | ☐ | Permanent defect from Illness, Disease or Injury: _____ |
| ☐ | ☐ | Respiratory Disease – Type _____ | | | Other: _____ |

**YOUR OCULAR HISTORY** (Have <u>you</u> been diagnosed with any of the following in the past?)

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Cataracts _____ | ☐ | ☐ | Crossed Eyes/Lazy Eye _____ |
| ☐ | ☐ | Glaucoma _____ | ☐ | ☐ | Iritis/Inflammation in Eye _____ |
| ☐ | ☐ | Retinal Disease _____ | ☐ | ☐ | Corneal Disease _____ |
| ☐ | ☐ | Injury _____ | ☐ | ☐ | Other Eye Disorders _____ |

**If you have had cataract surgery, please write which eye and what year:** _____

**Please list any previous eye surgeries:** _____

**YOUR SURGICAL HISTORY** (Please include date and type: Continue on extra sheet if needed.)

_____

_____

Continued on reverse side.

**VACCINES**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | **Influenza vaccine received? Date: _____** | ☐ | ☐ | **Pneumococcal vaccine received? Date: _____** |

**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:** (Continue on extra sheet if needed.)

| | | **(Eye Medications/Drops)** |
|---|---|---|
| _____ | _____ | (_____) |
| _____ | _____ | (_____) |
| _____ | _____ | (_____) |

**PLEASE LIST ALL MEDICATIONS YOU ARE <u>ALLERGIC TO OR CIRCLE NONE:</u>**

_____ _____ _____ _____ **NONE**

**PHARMACY**

Pharmacy Name: _____ Address: _____ Phone: _____

**FAMILY HISTORY** (Has anyone in your family – blood relative – had any of the following?)

**<u>Note relation to Patient</u>: F-Father M-Mother B-Brother S-Sister GF-Grandfather GM-Grandmother U-Uncle A-Aunt**

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | **Glaucoma _____** | ☐ | ☐ | **Macular Degen. _____** | ☐ | ☐ | **Retinal Detachment _____** | ☐ | ☐ | **Diabetes _____** |
| ☐ | ☐ | **Cataracts _____** | ☐ | ☐ | **Corneal Disease _____** | ☐ | ☐ | **Diabetic Retinopathy _____** | | | |
| ☐ | ☐ | **Other Eye Problems _____** | | | | | | | | | |

**SOCIAL HISTORY**

**Marital Status** (Circle One): **Married Widowed Single Divorced Separated Partner Unknown**

**Smoking/Tobacco Use** (Circle One): **Never Smoker Former Smoker Every day Smoker Occasional Smoker**

**If a smoker, how many packs of cigarettes per day/week?: _____**

**If a former smoker, when did you/the patient quit: _____**

**Alcohol Use** (Circle One): **None Occasional/Social 1 – 2 Drinks/day 3 – 4 Drinks/day**

**Occupation** (Circle One): **Working-Occupation: _____ Retired Unemployed Disabled**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | **Have you/the patient fallen in the last 12 months? If yes, date: _____** |
| ☐ | ☐ | **Do you live alone? _____** |
| ☐ | ☐ | **Psychiatric disorders? _____** |
| ☐ | ☐ | **Are you/the patient currently staying in a nursing home or rehab center? Name: _____** |
| ☐ | ☐ | **Are you/the patient currently staying in hospice? Name: _____** |

**Patient signature: _____ Date: _____**

*Must be updated by patient every 3 years.*