MEDICAL INFORMATION

DATE____________________________REFERRED BY_________________________

NAME:___________________________FAMILY DOCTOR:_____________________

I. PAST HISTORY

1. Medication Allergies:

2. List of current Medication (including eye medications and over-the-counter):

3. Past Surgical History:

4. Medical History: Have **<u>you</u>** ever had any of the following?

	NO	YES		NO	YES
Diabetes	☐	☐	Tuberculosis	☐	☐
High Blood Pressure	☐	☐	Syphilis/gonorrhea	☐	☐
Heart Disease	☐	☐	HIV infection/AIDS	☐	☐
Stroke	☐	☐	Thyroid disease	☐	☐
Asthma or Bronchitis	☐	☐	Migraine headaches	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐
Arthritis	☐	☐	Retinal Detachment	☐	☐
Macular Degeneration	☐	☐	Glaucoma	☐	☐
Blindness	☐	☐	Cataracts	☐	☐
Other eye disease:_____________			Other medical condition:____________		

II. FAMILY HISTORY:

	NO	YES		NO	YES
Diabetes	☐	☐	High Blood Pressure	☐	☐
Heart Disease	☐	☐	Stroke	☐	☐
Asthma/Bronchitis	☐	☐	Thyroid Disease	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐
Macular Degeneration	☐	☐	Blindness	☐	☐
Retinal Detachment	☐	☐	Other eye disease	☐	☐

III. SOCIAL HISTORY

	NO	YES
Do you consume alcohol regularly?	☐	☐
Do you smoke cigarettes or a pipe?	☐	☐
Have you been exposed to hazardous materials?	☐	☐
Have you been exposed to excessive sun?	☐	☐

What is your current occupation?____

PLEASE CONTINUE ON REVERSE SIDE **OVER**

REVIEW OF SYSTEMS

Do you currently have any of these problems?

1. Constitutional:
   - Fever ☐
   - Weight Loss ☐
   - Other ☐
2. Eyes:
   - Blurred Vision ☐
   - Poor Vision ☐
   - Pain ☐
   - Decreased vision ☐
   - Other ☐
3. Ears, Nose, Mouth, Throat:
   - Stuffy nose ☐
   - Ear ache ☐
   - Dry mouth ☐
   - Hearing Loss ☐
   - Cough ☐
   - Other ☐
4. Cardiovascular:
   - Irregular heart beat ☐
   - Chest Pain ☐
   - High Blood pressure ☐
   - Racing pulse ☐
   - Other ☐
5. Respiratory:
   - Shortness of breath ☐
   - Congestion ☐
   - Asthma (wheezing) ☐
   - Other ☐
6. Gastrointestinal:
   - Bowel habits/change ☐
   - Diarrhea ☐
   - Constipation ☐
   - Stomach pain ☐
   - Ulcers ☐
   - Other ☐
7. Hematologic Lymphatic:
   - Anemia ☐
   - Blood Disorder ☐
   - Free Bleeder ☐
   - Swollen Lymph Nodes ☐
   - Other ☐
8. Neurological:
   - Numbness ☐
   - Paralysis ☐
   - Seizures ☐
   - Other ☐
9. Muscoloskeletal:
   - Stiffness ☐
   - Joint Pain ☐
   - Muscle Weakness ☐
   - Cramps ☐
   - Other ☐
10. Skin:
    - Pimples ☐
    - Warts ☐
    - Rash ☐
    - Growths ☐
    - Other ☐
11. Endocrine:
    - Diabetes ☐
    - hypothyroid ☐
    - hyperthyroid ☐
12. Psychiatric:
    - Anxiety ☐
    - depression ☐
    - insomnia ☐
    - Other ☐

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Information reviewed and updated:

Month/Year	Dr. Initials	Tech Initials	Month/Year	Dr. Initials	Tech Initials	Month/Year	Dr. Initials	Tech Initials
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Updated: 06/09/2009