Patient Ocular and Medical History

Patient Name: ______________________________ Male/Female: ___________ Date: ____________

Name of Primary Care Physician: _________________________ Other Doctor(s): ________________________

Last Eye Exam: Date: _______________ Location: _____________________ Doctor: _________________

Personal Medical History:

*Have **you** ever been diagnosed with:*

Glaucoma	Yes	No	Diabetes	Yes	No
Cataracts	Yes	No	Heart Disease	Yes	No
Retinal Detachment	Yes	No	High Blood Pressure	Yes	No
Eye Injury	Yes	No	High Cholesterol	Yes	No
"Lazy Eye"	Yes	No	Stroke	Yes	No
Diabetic Eye Disease	Yes	No	Cancer ________________	Yes	No
Thyroid Eye Disease	Yes	No	Thyroid Disease	Yes	No
Macular Degeneration	Yes	No	Multiple Sclerosis	Yes	No
Other ____________________________			HIV/AIDS	Yes	No
_________________________________			Migraines	Yes	No
_________________________________			Asthma/Emphysema (circle)	Yes	No

List all major **surgeries**, injuries, and/or hospitalizations you have had: ________________________________
____

List any **eye surgeries**: ____

List all **medications** (Prescription/Over the Counter): ______________________________________
____
____

Do you have any **allergies** to medications?	Yes	No	If yes, list: ___________________________
Do you have any **seasonal/food allergies**?	Yes	No	If yes, list: ___________________________
Are you **pregnant**?	Yes	No	

Social History:

Do you use tobacco?	Yes	No	Type: __________________	Quantity: __________________
Do you drink alcohol?	Yes	No	Type: __________________	Quantity: __________________
Do you drive?	Yes	No		
Do you use any other drugs?	Yes	No	Type: __________________	Quantity: __________________

Circle if you have been exposed to or infected with: Gonorrhea Syphilis HIV Hepatitis

Family Medical History: Has anyone in your family had... (Please list relationship to you)

Macular Degeneration	Yes	No	____
Glaucoma	Yes	No	____
"Lazy Eye"	Yes	No	____
Cataracts	Yes	No	____
Diabetes	Yes	No	____
High Blood Pressure	Yes	No	____
Heart Disease	Yes	No	____
Other ________________	Yes	No	____

(over)

<u>Review of Systems:</u>

Do you currently have or ever had any problems in the following areas:

Eyes			
Poor vision	Yes	No	?
Eye pain	Yes	No	?
Tearing	Yes	No	?
Redness	Yes	No	?
Jaw pain	Yes	No	?
Scalp tenderness	Yes	No	?
Transient vision losses	Yes	No	?
Loss of vision	Yes	No	?
Constitutional/Symptom			
Fever	Yes	No	?
Chills	Yes	No	?
Weight loss	Yes	No	?
Ear, Nose, Throat, Mouth			
Stuffy nose	Yes	No	?
Ear ache	Yes	No	?
Cough	Yes	No	?
Cardiovascular			
High blood pressure	Yes	No	?
Rapid heartbeat	Yes	No	?
Respiratory			
Congestion	Yes	No	?
Wheezing	Yes	No	?
Shortness of breath	Yes	No	?
Gastrointestinal			
Upset stomach	Yes	No	?
Diarrhea	Yes	No	?
Constipation	Yes	No	?

Genitourinary			
Burning on urination	Yes	No	?
Urinary frequency	Yes	No	?
Incontinence	Yes	No	?
Musculoskeletal			
Joint pains	Yes	No	?
Stiffness	Yes	No	?
Arthritis	Yes	No	?
Integumentary			
Rash	Yes	No	?
Changing moles	Yes	No	?
Neurological			
Headache	Yes	No	?
Seizure	Yes	No	?
Stroke	Yes	No	?
Paralysis	Yes	No	?
Psychiatric			
Anxiety	Yes	No	?
Depression	Yes	No	?
Insomnia	Yes	No	?
Endocrine			
Diabetes	Yes	No	?
Thyroid abnormalities	Yes	No	?
Hematologic/Lymphatic			
Bleeding Disorders	Yes	No	?
Anemia	Yes	No	?
Allergic/Immunologic			
Allergies/Hay Fever	Yes	No	?
Hives	Yes	No	?

Please list any other health-related issues you have been diagnosed with not mentioned above: ______________

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Doctor's Notes:

Reviewed by:

Clinician: ______________________________________ Date: ________________________