In order to better treat you, please provide the following medical history.

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

Who is your family physician? _____

Ocular History

Have you ever been diagnosed with:

	Yes	No
Dry eyes	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Diabetic Retinopathy	☐	☐
Retinal Detachment	☐	☐
Retinal Diseases	☐	☐
"Lazy Eye"	☐	☐

Please list any eye drops or oral eye vitamins you are taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you had any eye surgery or eye trauma? Please describe:

Systemic History

Do you have or have you previously had a medical history of:

	Yes	No
High Blood Pressure	☐	☐
Diabetes	☐	☐
Congestive Heart Failure	☐	☐
Coronary Artery Disease	☐	☐
Thyroid Disease	☐	☐
Stroke	☐	☐
What year?_____		
Heart Attack	☐	☐
What year?_____		
Pacemaker	☐	☐
Cancer	☐	☐
What kind?_____		

Please list any medications you are currently taking, including over-the-counter medications:

Medication	Dosage

Are you allergic to any medications or drugs? ☐ **Yes** ☐ **No known drug allergies**
If yes, please list and describe effect:

Family History

Do you have a family history of:

	Yes	No
High Blood Pressure	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Retinal Detachment	☐	☐
Retinal Disease	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

Social History

	Yes	No
Do you smoke cigarettes?	☐	☐
If yes, how much per day? _____		
Do you drink alcohol?	☐	☐
If yes, please circle	Social	Daily
Do you drink caffeine?	☐	☐
If yes, how much per day? _____		
Do you now or have you ever used recreational drugs?	☐	☐

Continued on back

REVIEW OF SYSTEMS

Please check and circle all that apply to you, and if needed list any brief details to the side.

	Yes	No	
Constitutional Symptoms	☐	☐	_____

(fatigue, headaches, insomnia, night sweats, recent fever, weakness, weight gain or weight loss, etc)

Ears, Nose, Mouth & Throat	☐	☐	_____

(hearing loss, hoarseness, nasal congestion, ringing in ears, sinus problems, sore throat, vertigo, etc)

Respiratory	☐	☐	_____

(asthma, blood in spit, bronchitis, cough, emphysema, irregular breathing, pain with breathing, short of breath, tuberculosis exposure, wheezing, etc)

Cardiovascular	☐	☐	_____

(calf pain with exercise, chest pain or pressure, irregular hearth rhythm, leg swelling, palpitations, rapid heart rate, shortness of breath with exertion, etc)

Gastrointestinal	☐	☐	_____

(abdominal pain, black tarry stools, constipation, decreased appetite, diarrhea, food intolerance, heartburn, increased appetite, jaundice, nausea, trouble swallowing, vomiting, etc)

Genitourinary	☐	☐	_____

(abnormal menstruation, blood in urine, genital sores, pain with urination, urinary discharge, urinary urgency, etc)

Integumentary/Skin	☐	☐	_____

(abnormal finger nails, abnormal hair change, abnormal lesions, dry skin, hives, itchy skin, skin color change, skin lump, skin rash, skin ulcer, sores, unusual rashes, etc)

Endocrine	☐	☐	_____

(bulging eyes, cold intolerance, heat intolerance, increased thirst, increased urination, mass in front of neck, etc)

Neurological	☐	☐	_____

(balance problems, dizziness, fainting, headaches, local weakness, memory problems, numbness of extremities, seizures, tingling, tremors, vertigo, etc)

Psychological	☐	☐	_____

(excessively elevated mood, frequent nightmares, hallucinations, irritability, low mood, nervousness, tension, etc)

Musculoskeletal	☐	☐	_____

(arthritis, back pain, easily broken bones, joint pain, joint stiffness, muscle pain, muscle wasting, night cramps, etc)

Hematologic/Lymphatic	☐	☐	_____

(bleeding, blood transfusion, bruising, enlarged lymph nodes, tender lymph nodes, etc)

Allergic/Immunologic	☐	☐	_____

(hives, seasonal allergies, etc)

Please list any other medical conditions not previously listed: