

# CONFIDENTIAL MEDICAL HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

**Medical History** Date of last physical exam? \_\_\_\_\_

Do you have any allergies to medications?  no  yes if yes, explain: \_\_\_\_\_

List any medications you are taking (including oral contraceptives, over the counter medications, and home remedies)

Medications: \_\_\_\_\_ or  No Meds taken

Name of primary care doctor? \_\_\_\_\_ Dr.'s phone number if known \_\_\_\_\_

**Ocular History** Date of last eye exam? \_\_\_\_\_

Do you wear glasses?  no  yes if yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?  no  yes if yes, how old is your present pair of lenses? \_\_\_\_\_

Have you ever had any eye injuries or surgeries?  no  yes if yes, explain: \_\_\_\_\_

**Personal/Family History** Please answer the questions below regarding you or your immediate family (parents, grandparents, siblings, and children). Answers for you and family are separated, be sure that you are checking within the appropriate column.

	<u>You</u>		<u>Family</u>			<u>How are they related to you?</u>
	Yes	No	Yes	No	?	
Blindness/Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Social History**

Do you use tobacco products, drink alcohol, or use illegal drugs?  yes  no if yes, what type/amount/frequency? \_\_\_\_\_

**Review of Systems**

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

	Yes	No	?		Yes	No	?
<b><i>Constitutional</i></b>				<b><i>Ears/Nose, Mouth, Throat</i></b>			
Fever/Weight Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><i>Integumentary (Skin)</i></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><i>Neurological</i></b>				<b><i>Respiratory</i></b>			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><i>Eyes</i></b>				<b><i>Vascular</i></b>			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><i>Endocrine (Thyroid/other glands)</i></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes of Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><i>Gastrointestinal</i></b>			
Floater in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Trauma/Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><i>Genitourinary</i></b> Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching/Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><i>Psychiatric/Depression</i></b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><i>Lymphatic/Hematologic</i></b>			
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><i>Bones/Joints/Muscles</i></b>				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><i>Other</i></b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>