Pingree Eye Center

Medical History Information

Date: _____ Name:_____ Date of Birth: ____/____/_____
Last First MI

Referring Physician:_____ Primary Care Physician:_____

Pharmacy (Name, Phone # and Address): _____

Reason for your visit today:_____

Do you wear Glasses? **Yes** **No** Do you wear Contacts? **Yes** **No**

Your Eye History- Have you ever been diagnosed or experienced the following?

Check all that apply:

- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Dry Eye
- ☐ Excess Watering
- ☐ Difficulty Seeing Near
- ☐ Difficulty Seeing Distance
- ☐ Floaters
- ☐ Flashing Lights
- ☐ Foreign Body Sensation
- ☐ Corneal Disease
- ☐ Crossed Eyes/Lazy Eye
- ☐ Iritis
- ☐ Eye Infection(s)
- ☐ Eye Trauma

Please list any current Eye Drops or Eye Medication you are currently using: _____
_____

Your Eye Surgery History – Have you had any of the following?

Check all that apply:

- ☐ Cataract Surgery R / L
- ☐ Corneal Transplant
- ☐ LASIK or PRK
- ☐ Laser Surgery (SLT / YAG)
- ☐ Diabetic Laser Surgery
- ☐ Glaucoma Surgery
- ☐ Pterygium Surgery
- ☐ Retinal Surgery
- ☐ Eye Muscle (Stabismus) Surgery

Your Medical History- Have you ever been diagnosed or experienced the following?

Check all that apply:

- ☐ Diabetes Type I / Type II
  - Last A1C Level:_____
  - Last Blood Sugar Reading:_____
  - Date of last Blood Sugar:_____
  - # Years with Diabetes: _____
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Cholesterol High / Low
- ☐ Stroke
- ☐ Cancer /Type_____
- ☐ Asthma
- ☐ Lung Disease
- ☐ Shortness of Breath
- ☐ Intestinal Problems
- ☐ Ulcer / Acid Reflux
- ☐ Kidney Disease
- ☐ Urinary Problems
- ☐ Thyroid Disease
- ☐ Blood Problems
- ☐ Migraines
- ☐ Seizures
- ☐ Memory Loss
- ☐ Weakness/Numbness
- ☐ AIDS / HIV
- ☐ Staph Infection
- ☐ Weight Loss/Gain
- ☐ Arthritis / Joint Pain
- ☐ Fever/Chills
- ☐ Skin Problems
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Nausea / Vomiting
- ☐ Abdominal Pain
- ☐ Anxiety
- ☐ Depression
- ☐ Seasonal Allergies

Details (If you wish to explain):_____
_____

Please Turn Over to Complete 2014.5.16

Your Medical History- Continued

Yes	No	
☐	☐	Do you use Supplemental Oxygen?
☐	☐	Do you use a CPAP/BIPAP at night?
☐	☐	(Women) Are you currently pregnant?
☐	☐	(Men) Do you have prostate problems?
☐	☐	Are you currently living in a Skilled Nursing Facility? If yes, Predicted Discharge Date:_____

Your Family History – Has anyone related to you had the following?

Check all that apply:	Relationship (Please Circle)					
☐ Glaucoma	Mother	Father	Sibling	Grandparent	Child	Other _____
☐ Macular Degeneration	Mother	Father	Sibling	Grandparent	Child	Other _____
☐ Diabetes	Mother	Father	Sibling	Grandparent	Child	Other _____
☐ High Blood Pressure	Mother	Father	Sibling	Grandparent	Child	Other _____
☐ Cataracts	Mother	Father	Sibling	Grandparent	Child	Other _____
☐ Retinal Detachment	Mother	Father	Sibling	Grandparent	Child	Other _____
☐ Thyroid Disease	Mother	Father	Sibling	Grandparent	Child	Other _____
☐ Keratoconus (Cornea Disease)	Mother	Father	Sibling	Grandparent	Child	Other _____
☐ Crossed Eyes / Lazy Eye	Mother	Father	Sibling	Grandparent	Child	Other _____

Your Surgical History – Please list all previous surgeries

_____

_____

_____

Your Current Medications – Please list ALL prescription medications you are currently taking

_____

_____

_____

_____

_____

Your Medical Allergies – Please list any allergies to medications

_____

_____

Your Social History

Yes	No	
☐	☐	Do you Smoke? If Yes, _____packs/day
☐	☐	Are you a former smoker?
☐	☐	Do you drink Alcohol? If Yes, please circle: Often / Occasional

What is your current Occupation?_____

Thank you for filling out Your Health History and Information