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 □ Difficulty Seeing Near □ Corneal Disease

□ Macular Degeneration □ Difficulty Seeing Distance □ Crossed Eyes/Lazy Eye

□ Glaucoma □ Floaters □ Iritis

□ Dry Eye □ Flashing Lights □ Eye Infection(s)

□ Excess Watering □ Foreign Body Sensation □ Eye Trauma

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

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

**Check all that apply:**

□ Cataract Surgery R / L

□ Corneal Transplant

□ LASIK or PRK

□ Pterygium Surgery

□ Retinal Surgery

□ Eye Muscle (Stabismus) Surgery

□ Laser Surgery (SLT / YAG)

□ Diabetic Laser Surgery

□ Glaucoma Surgery

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

□ Staph Infection

□ Weight Loss/Gain

□ Arthritis / Joint Pain

□ Fever/Chills

□ Skin Problems

□ Sinus Problems

□ Sore Throat

□ Nausea / Vomiting

□ Abdominal Pain

□ Anxiety

□ Depression

□ Seasonal Allergies

□ Shortness of Breath

□ Intestinal Problems

□ Ulcer / Acid Reflux

□ Kidney Disease

□ Urinary Problems

□ Thyroid Disease

□ Blood Problems

□ Migraines

□ Seizures

□ Memory Loss

□ Weakness/Numbness

□ AIDS / HIV

**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

Details (If you wish to explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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**

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

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 **Your Medical Allergies – Please list any allergies to medications**

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**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**

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