PATIENT MEDICAL HISTORY RECORD

Name: _____ **Occupation:** _____ **Employer:**_____

Primary Doctor:_____ **Specialist Doctor(s):**_____

PAST MEDICAL HISTORY (MARK YES OR NO TO EACH QUESTION)

Arthritis	☐ Yes	☐ No	Hypercholesterolemia (high cholesterol)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hypertensive disorder (Hypertension)	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Seasonal allergy	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No	Thyroid dysfunction	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No	Rheumatoid arthritis	☐ Yes	☐ No

Are you being treated for any medical conditions? (e.g. Diabetes, High blood pressure,arthritis) ☐ Yes ☐ No

If yes: _____

Have you ever had any eye disease? (e.g. glaucoma, cataract, lazy eye, retinal detachment) ☐ Yes ☐ No

If yes,please provide date and reason: _____

_____

Have you ever had any surgery? ☐ Yes ☐ No If yes: _____

Any hospitalizations? ☐ Yes ☐ No If yes,please provide date and reason:_____

_____

Do you take any medications? ☐ Yes ☐ No If yes, please list all ACTIVE and CURRENT medications
(Attach a copy if needed)

_____

_____

Any food or drug allergies? ☐ Yes ☐ No If yes, please list allergies you may have

_____

Family and Social History

Do ANY medical or eye diseases run in your family ? (e.g. Diabetes, High blood pressure, Cancer, Glaucoma,Macular Degeneration) ☐ **Yes** ☐ **No If yes, please explain:**_____

Do you smoke? ☐ **Yes** ☐ **No** How many packs per day? _____ Drink Alcohol? ☐ **Yes** ☐ **No**

Comments _____

REVIEW OF SYSTEMS:

Do you currently have, or have you ever had, any of the following problems or conditions?

Chronic Fever, unexpected weight loss/gain, fatigue? ☐ **Yes** ☐ **No** _____

Ear/Nose/Throat Problems (e.g. Hearing Loss, Sinus problems, Sore throat) ☐ **Yes** ☐ **No** _____

Heart problems (e.g. chest pain, irregular heart beat) ☐ **Yes** ☐ **No**_____

Respiratory problems (e.g. shortness of breath, wheezing, coughing) ☐ **Yes** ☐ **No** _____

Urinary problems (e.g. pain or discomfort, blood in urine) ☐ **Yes** ☐ **No** _____

Skin problems (e.g. rashes, itching,dryness) ☐ **Yes** ☐ **No** _____

Musculoskeletal problems (e.g. muscle pain, joint pain, swollen joints) ☐ **Yes** ☐ **No** _____

Neurologic problems (e.g. numbness, weakness, headache, paralysis) ☐ **Yes** ☐ **No** _____

Psychiatric problems(e.g. Depression, anxiety) ☐ **Yes** ☐ **No** _____

_____ _____ _____

SIGNATURE DATE Physician's Initials