MEDICAL HISTORY • SYMPTOM • SURGICAL INFORMATION

NAME: _____ **DATE: _____**

SYMPTOMS:	
EYES:	loss of vision blurred vision fluctuated vision distorted vision loss of side vision double vision dryness mucus redness sandy or gritty feeling burning or itching foreign body sensation excess tearing/watering glare and light sensitivity eye pain or soreness
GENERAL:	fever weight loss fatigue
EARS, NOSE, THROAT:	hard of hearing ear ache cough dry mouth sinus/allergy hoarseness vertigo
GASTROINTESTINAL:	upset stomach diarrhea constipation
RESPIRATORY:	congestion wheezing short of breath TB exposure
GENITOURINARY:	painful/ frequent urination impotence yellow jaundice blood in urine
DERMATOLOGIC:	warts growths rash
ENDOCRINE:	increased thirst increased urination increased hunger
ALLERGIC/IMMUNOLOGIC:	sneezing swelling redness itching
CARDIOVASCULAR:	chest pain racing pulse irregular heartbeat heart palpitations
HEMATOLOGY:	bleeding
MUSCULOSKELETAL:	joint pain stiffness swelling
PSYCHIATRIC:	history of substance abuse anxiety depression insomnia
NEUROLOGICAL:	numbness headache seizures paralysis memory loss
FEMALES:	Are you pregnant? **YES** **NO** Are you nursing? **YES** **NO**

FAMILY HISTORY: Does any member **of your immediate family (blood relatives)** have these diseases?

Disease/Condition	**FAMILY MEMBER**	**Disease/Condition**	**FAMILY MEMBER**
Lazy Eye	Mother Father Sibling Grandparent	Diabetes	Mother Father Sibling Grandparent
Blindness	Mother Father Sibling Grandparent	Heart Disease	Mother Father Sibling Grandparent
Cataracts	Mother Father Sibling Grandparent	High Blood Pressure	Mother Father Sibling Grandparent
Glaucoma	Mother Father Sibling Grandparent	High Cholesterol	Mother Father Sibling Grandparent
Macular Degeneration	Mother Father Sibling Grandparent	Kidney Disease	Mother Father Sibling Grandparent
Retinal Disorders	Mother Father Sibling Grandparent	Lung Disease	Mother Father Sibling Grandparent
Arthritis	Mother Father Sibling Grandparent	Lupus	Mother Father Sibling Grandparent
Cancer	Mother Father Sibling Grandparent	Stroke	Mother Father Sibling Grandparent
Type of cancer: _____		Thyroid Disease	Mother Father Sibling Grandparent

SOCIAL HISTORY

Do you smoke?

☐ Current Everyday ☐ Current Some Days

☐ Former ☐ Never

How many packs of cigarettes per day? _____

Do you drink?

☐ Rarely ☐ Occasionally

☐ Socially ☐ Frequently

☐ Never

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DISEASES:	**Circle any and all conditions that apply to you** or circle none. **NONE**
EYES:	blindness cataracts diabetic retinopathy glaucoma macular degeneration retinal detachment lazy eye eye trauma amblyopia crossed eyes drooping eyelid
EARS, NOSE, THROAT:	allergic rhinitis vertigo seasonal allergies
GASTROINTESTINAL:	hernia peptic ulcer disease crohn's ulcerative colitis reflux (GERD)
RESPIRATORY:	asthma COPD emphysema chronic bronchitis
GENITOURINARY:	kidney stones kidney failure
DERMATOLOGIC:	acne eczema melanoma psoriasis rosacea cancer **(specify type)** _____
ENDOCRINE:	grave's disease thyroid disease hypoglycemia diabetes **(specify type)** Type1□ Type2□ Controlled□ Uncontrolled□ Insulin Dependent? Yes □ No □
ALLERGIC/IMMUNOLOGIC:	HIV+ lupus sjogren's syndrome rheumatoid arthritis herpes simplex virus hepatitis A/B shingles reiter's syndrome ankylosing spondylitis
CARDIOVASCULAR:	atrial fibrillation congestive heart failure heart attack heart arrhythmia high blood pressure high cholesterol
HEMATOLOGY:	anemia blood clot in lungs blood clot in legs low platelets
MUSCULOSKELETAL:	fibromyalgia multiple sclerosis arthritis carpal tunnel syndrome gout osteoporosis
PSYCHIATRIC:	anxiety depression bipolar disorder insomnia other _____
NEUROLOGICAL:	alzheimer's dementia parkinson's stroke autism bell's palsy epilepsy schizophrenia migraines

MEDICATION / ALLERGY INFORMATION

Eye Medications	Dosage	Frequency	**Eye Medications**	Dosage	Frequency
Systemic Medications	Dosage	Frequency	**Systemic Medications**	Dosage	Frequency

Please list all medication / food allergies that you have: (Please include reaction to allergy)

_____ _____

_____ _____

_____ _____

Eye Surgeries / Procedures	Date	Eye Surgeries / Procedures	Date
General Surgeries	Date	**General Surgeries**	Date

Primary Care Physician:

Name: _____

Phone #: _____

Address: _____

_____

Pharmacy Contact Information:

Name: _____

Phone #: _____

Address: _____

_____

Patient Signature: _____ **Date:** _____