

Patient Medical History

Name _____ Date of birth ____/____/____ Date ____/____/____

Referring Doctor _____ Regular/Primary Care Doctor _____

What is the reason for your visit today? _____ Which eye is this for? Left Right Both

What other symptoms do you have? (mark all that apply)

Blurred vision Curtain in vision Double vision Flashes Floaters Light sensitivity Pain Vision loss Other _____

How long have you been experiencing these problems?

Unsure 1-2 days 3-5 days 1 week 2-3 weeks 1 month 3-5 months 6 months 1 year Many years Lifelong

What are your other eye problems? (mark all that apply)

AMD (macular degeneration) Diabetic retinopathy Retinal detachment
 Blocked vein or artery in eye Dry eye Other _____
 Cataracts Glaucoma

Do you have diabetes? No Type 1 Type 2 How many years have you had it? _____ What is your A1C level? _____

Please mark any of medical problems you have:

AIDS/HIV Asthma Gout Kidney disease Seizures
 Alzheimer's Cancer Heart disease Liver disease Stroke
 Anemia Cerebral palsy High cholesterol Migraines Thyroid disease
 Arthritis Dementia Hypertension Parkinson's Other _____

Have you had any of the following eye surgeries? (mark all that apply and mark the corresponding eye)

Cataract surgery Left Right Glaucoma surgery Left Right
 LASIK surgery Left Right Retina surgery Left Right

Please list all other past surgeries: None _____

Please list all medications/eyedrops you currently use: None _____

Please list any medication allergies you have: None _____

Family medical history (mark all that apply):

AMD (macular degeneration) Cataract Heart disease Stroke
 Amblyopia (lazy eye) Coronary artery disease High cholesterol Thyroid disease
 Arthritis or rheumatism Diabetes Hypertension Uveitis
 Blindness Glaucoma Kidney disease Other _____
 Cancer Headaches/Migraines Retinal detachment

Do you smoke? Never smoker Former smoker Occasional smoker Light smoker Heavy smoker

Do you drink alcohol? No Occasionally/Socially 1-2 drinks a day 3-4 drinks a day

Do you use street drugs? No Yes (list drugs) _____

Are you pregnant? No Yes

Are you currently under hospice care? Yes No

PLEASE COMPLETE OTHER SIDE OF PAPER

Review of Systems

Please mark all that you are **currently** experiencing

Allergy/Immunology

- Autoimmune disease
- Seasonal allergies

Cardiovascular

- Chest pain
- Shortness of breath
- Swelling of the feet
- Shortness of breath when lying flat
- Racing pulse
- Irregular heartbeat

Constitutional

- Fever
- Weight loss
- Fatigue
- Loss of appetite
- Chills
- Night sweats
- Feel sick
- Poor appetite

Endocrine

- Excess thirst
- Excessive urination
- Heat intolerance
- Cold intolerance
- Hair loss
- Dry skin

Gastrointestinal

- Abdominal pain
- Nausea
- Diarrhea
- Bloody stools
- Stomach ulcers
- Constipation
- Trouble swallowing
- Gastrointestinal ulcers
- Jaundice or yellow skin

Genitourinary

- Pain/burning on urination
- Blood in urine
- Bladder trouble
- Dialysis
- Genital sores or ulcers
- Kidney failure
- Kidney problems
- Kidney stones
- Prostatitis
- Testicular pain
- Urinary discharge

Hematology/Oncology

- Easy bruising
- Prolonged bleeding

Head/Ears/Nose/Throat (HENT)

- Hearing loss
- Sore throat
- Runny nose
- Dry mouth
- Jaw claudication (pain chewing)
- Ear ache

Integumentary

- Rash
- Change in mole
- Skin sores
- Skin cancer
- Severe itching

Musculoskeletal

- Muscle aches
- Joint pain
- Difficulty lying flat
- Back pain during/after sleep

Neurological

- Weakness
- Headaches
- Scalp tenderness
- Dizziness
- Paralysis of extremities
- Tremor
- Stroke
- Numbness
- Tingling
- Seizures or convulsions
- Fainting

Psychiatric

- ADHD
- Anxiety
- Bipolar disorder
- Depression

Respiratory

- Wheezing
- Cough
- Coughing up blood
- Severe or frequent colds
- Difficulty breathing

Other problems

None of the above