PATIENT MEDICAL STATUS AND HISTORY RECORDS

Name: _____ Date (MM/DD/YY): _____

PLEASE ANSWER THE FOLLOWING:

WHAT IS (ARE) THE PRESENT PRIMARY PROBLEM(S) WITH YOUR EYE(S)? _____

_____

_____

1. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?

☐No ☐Yes If Yes, please explain: _____

_____

2. Have you ever had any eye surgery?

☐No ☐Yes If Yes, please provide the date and surgical procedure: _____

. _____

3. Have you ever had any surgery (other than eye surgery)?

☐No ☐Yes If Yes, please provide date and surgical procedure: _____

_____

4. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, heart problems, stroke, etc.)?

☐No ☐Yes If Yes, please explain: _____

_____

5. Have you ever been hospitalized?

☐No ☐Yes If Yes, please provide date and reason: _____

_____

6. Do you take any medications?

☐No ☐Yes If Yes, please indicate medication and dosage: _____

_____

_____

7. Do you have any drug or food allergies?

☐No ☐Yes If Yes, please explain: _____

FAMILY AND SOCIAL HISTORY

Do any medical or diseases run in your family? (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

☐No ☐Yes If Yes, please explain: _____

_____

Do you smoke? _____ If yes, how much?_____
Drink alcohol? _____If yes, how much? _____

Current occupation or previous profession? _____

OVER►

REVIEW OF SYSTEMS **Do you currently have any of the following problems?**	**No**	**Yes**	**If Yes, please explain:**
Chronic fever, unexpected weight loss/gain, fatigue, weakness.	☐	☐	_____
Ear/nose/throat problems: hearing loss, sinus problems ringing in the ears.	☐	☐	_____
Cardiovascular (heart/blood vessels): chest pain, irregular heartbeat, blood clots, High blood pressure, heart murmur, stent, chronic heart failure, pacemaker. high cholesterol, circulation problems.	☐	☐	_____
Respiratory (lungs/breathing): shortness of breath, wheezing, coughing, asthma, sleep apnea, emphysema (c-pap machine?)	☐	☐	_____
Gastrointestinal (stomach/intestines): heartburn, diarrhea, vomiting nausea, GERD, ulcer, hiatal hernia, acid reflux, constipation.	☐	☐	_____
Genitourinary (genitals/kidney/bladder): pain or discomfort, blood in urine kidney disease and/or dialysis, frequent urination, prostrate problems.	☐	☐	_____
Skin: rashes, excessive dryness, rash, psoriasis, eczema, roseacia	☐	☐	_____
Musculoskeletal (bones/joints/muscles): muscle aches, swollen, painful joints osteoporosis, rheumatoid arthritis, lupus, gout, fibromyalgia.	☐	☐	_____
Neurological: e.g., numbness, weakness, headaches, paralysis, parkinsons, alzheimers, multiple sclerosis, peripheral neuropathy, stroke.	☐	☐	_____
Endocrine: e.g., thyroid problems, excessive sweating, diabetes	☐	☐	_____
Hematopoietic (blood): bruise easily, anemia, leukemia	☐	☐	_____
History of hepatitis, HIV/AIDS or other bloodborne pathogens	☐	☐	_____
Psychiatric: depression, anxiety, dementia, on meds	☐	☐	_____

M.D. Signature: _____Date:_____
Updated Information/ Date:

_____

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