Patient Medical History

Date: _____

Patient First and Last name: _____ **Date of Birth**: _____

Do you have ALLERGIES to MEDICATION? If yes, list allergies and reaction: _____

_____

List any MEDICATION you currently use: *Including Inhalers, Intravenous, and/or Topical* _____

_____

List any EYE DROPS you currently use: _____

_____

Pharmacy Name: _____ **Address**: _____

PERSONAL PAST MEDICAL HISTORY: Have you ever had the following diseases? (Please check Yes or No)

Have you ever had	YES	NO	
Amblyopia			Eye ☐ Right ☐ Left
Anemia			
Asthma/Emphysema			
Cancer			Type? Since?
Cataract			Eye ☐ Right ☐ Left
Congestive Heart Failure			Since?
Coronary Artery Disease			Since?
Dementia			Since?
Diabetes			Type:☐1 ☐2 year_____
Eye injury/infection			Eye ☐ Right ☐ Left
Eye Surgeries			Eye ☐ Right ☐ Left
Glaucoma			Eye ☐ Right ☐ Left
Heart Attack			When?
High Blood Pressure			Since?
Lupus			Since?
Pacemaker			Year?
Retinal Detachment			Eye ☐ Right ☐ Left
Stroke			When?

Have you ever had	YES	NO	
Arthritis/Rheumatoid Arthritis			
Epilepsy			
Hepatitis			Type?
Have you been exposed to AIDS virus (HIV)?			When?
Have you ever had a blood transfusion?			When?
Have you ever gone into Anaphylactic shock?			When?
Have you ever used IV drugs?			
Herpes			
Migraine headaches			
Multiple Sclerosis			
Shingles			When?
Thyroid problems			
Tuberculosis			
Ulcers of stomach			
Venereal Disease (STD)			Type?
Are you pregnant?			
Other:			

List all major *illnesses*, *injuries*, or *surgery* not described above: _____

_____

SOCIAL HISTORY:

	YES	NO	
Do you drink alcohol?			How often?
Have you ever smoked?			Quit in?
Substance abuse currently or in your past?			
Do you currently wear contacts or glasses?			
Do you drive?			
Do you have difficulty when driving?			
Current occupation?			

FAMILY HISTORY: Check box if yes

Has anyone in your ***IMMEDIATE*** family had:	Who?
☐ Retinitis Pigmentosa	
☐ Glaucoma	
☐ Retinal Detachment	
☐ High Blood Pressure	
☐ Cancer	
☐ Diabetes	

PLEASE TURN PAGE OVER

Patient First and Last name: _____ **Date of Birth**: _____

REVIEW OF SYSTEMS: Do you currently have any problems in the following areas? (Please check Yes or No)

Cardiovascular (heart/blood vessels)

Problems	YES	NO
Chest pain		
Irregular heart beat		
Difficulty controlling blood pressures		
Swelling of the feet		

Neurological

Problems	YES	NO
Severe headaches		
Numbness or tingling of extremities		
Seizures		
Scalp tenderness		

Constitutional Symptoms

Problems	YES	NO
Fever		
Weight Loss/Poor Appetite		
Fatigue/tire easily		

Respiratory

Problems	YES	NO
Chronic bronchitis/emphysema		
Chronic cough		
Shortness of breath		

Gastrointestinal

Problems	YES	NO
Stomach pain		
Diarrhea		
Nausea		

Musculoskeletal

Problems	YES	NO
Muscle aches		
Joint pains of stiffness		
Back pains or stiffness		

Genitourinary (genitals/kidney/bladder)

Problems	YES	NO
Burning with urination		
Genital sores		
Kidney infection or bleeding		

Ears, Nose, Mouth, Throat

Problems	YES	NO
Recent viral infection		
Sore throat		
Loss of hearing or deafness		
Dryness of mouth		

Hematology/Oncology

Problems	YES	NO
Easy bruising		
Prolonged bleeding		

Integumentary/Skin

Problems	YES	NO
Change in mole		
Rashes/facial acne		

Psychiatric

Problems	YES	NO
Depression/grieving/ anxiety		

Allergic/Immunologic

Problems	YES	NO
Hives		
Frequent severe infections		

Endocrine

Problems	YES	NO
Thyroid problems		
Excessive thirst		
Excessive urination		
Difficulty controlling blood sugars		
Cold/heat intolerance		

Eyes

Problems	YES	NO
Loss of vision		
Distorted vision		
Double vision		
Floating objects in vision		
Flashing lights		
Dryness of eyes		
Itching or redness		
Excess tearing		
Eye pain or soreness		

_____

Patient Signature

_____

Date