

MEDICAL HISTORY & REVIEW OF SYSTEMS

PLEASE PRINT

Name _____ Birth Date ____/____/____ Today's Date ____/____/____

Who referred you to us? _____ Family Physician _____ Marital Status _____

Do you drink alcohol? yes no rarely (PLEASE CIRCLE) Do you smoke? yes no (PLEASE CIRCLE) Occupation _____

Are you allergic to latex, penicillin, sulfa or any other medications? yes no *If yes, please list:*

Has any family member had:

Glaucoma? yes no _____ (list relatives)

Diabetes? yes no _____ (list relatives)

Corneal Transplant? yes no _____ (list relatives)

Retinal Detachment? yes no _____ (list relatives)

Macular Degeneration? yes no _____ (list relatives)

Other Eye Diseases? yes no _____ (list relatives)

Please list all current medicines that you take:

Have you had surgery or hospitalizations **not** involving the eyes? yes no

If yes, please describe: _____

DO YOU HAVE A HISTORY OF THE FOLLOWING MEDICAL PROBLEMS?

Circle Y or N	If yes, please describe
Y N	Retinal Detachment
Y N	Glaucoma
Y N	Arthritis / Lupus
Y N	Cancer
Y N	Diabetes
Y N	Heart Attack
Y N	Heart Failure
Y N	High Blood Pressure
Y N	Asthma/Emphysema
Y N	Kidney Stones
Y N	Stroke
Y N	HIV/AIDS
Y N	High Cholesterol
Y N	Other Illness

DO YOU CURRENTLY HAVE PROBLEMS WITH ANY OF THE FOLLOWING?

Circle Y or N	If yes, please describe
Y N	Ears/nose/throat: i.e. dry mouth
Y N	Heart: i.e. low blood pressure, heart failure or slow pulse
Y N	Lungs: i.e. cough, history of TB, sarcoid or lung cancer
Y N	General: i.e. fever or weight loss
Y N	Psychiatric: i.e. depression
Y N	Urinary: i.e. impotence or frequent urination
Y N	Neurologic: i.e. migraines or memory problems
Y N	Digestive: i.e. history of polyps, colon cancer or bloody stools
Y N	Muscles/joints: i.e. joint swelling, prednisone or steroid use
Y N	Blood/lymph: i.e. anemia or bleeding problems
Y N	Urinary: i.e. urination pain, sexually transmitted disease, syphilis

History of eye problems (including surgery or laser treatment on your eyes)? yes no *(If yes, please list all below with dates)*

Right Eye _____

Left Eye _____