

Fichman Eye Center

Medical History Form

____/____/____
DATE

PATIENT NAME

____/____/____
DATE OF BIRTH

MEDICAL STATUS AND HISTORY

Do you have any drug or food **allergies**? YES NO If yes, please list: _____

Do you take any **medications** for your **eyes**? YES NO If yes, please list: _____

Do you take any **other medications**? YES NO If yes, please list names and dosages: _____

Are your eyes: gritty? sandy? burning? tearing? watery? itching? NONE

Are your eyes bothered by: dry heat? wind? air conditioning? NONE

Have you ever had any of the following **eye diseases**?

- Glaucoma Cataracts Diabetic Retinopathy
 "Lazy" Eye Macular Degeneration Retinal Detachment

Have you ever had **eye surgery** or **laser procedures**? YES NO If yes, what and when: _____

Have you ever been treated for **diabetes**? YES NO If, yes how many years? _____ are you taking: Insulin Oral Medications

Have you ever been treated for any of the following **medical conditions**?

- Anemia Asthma Cancer
 Ulcers AIDS Stroke
 Arthritis Rheumatoid Arthritis High Blood Pressure
 Heart Disease Kidney Disease Thyroid Disease
 Liver Disease Blood Disorder High Cholesterol
 Other: _____

Have you ever been **hospitalized** or had **major surgery**? YES NO If yes, what and when: _____

For women only: Are you pregnant? YES NO Are you breast-feeding? YES NO

REVIEW OF SYSTEMS: Do you currently have any of the following problems?

- Chronic fever, weight loss/gain, fatigue
 Ear/Nose/Throat problems (i.e. hearing loss, sinus problems)
 Heart problems (i.e. chest pain, irregular heartbeat)
 Respiratory problems (i.e. shortness of breath)
 Gastrointestinal problems (i.e. heartburn, abdominal pain)
 Urinary problems (i.e. pain, blood in urine)
 Skin problems (i.e. rashes)
 Musculoskeletal problems (i.e. pain or swelling in joints)
 Neurological problems (i.e. numbness, weakness, headaches)
 Psychiatric problems (i.e. depression, anxiety)

FAMILY AND SOCIAL HISTORY:

Do any **medical** or **eye diseases** run in your **immediate family** (i.e. diabetes, high blood pressure, glaucoma, macular degeneration, retinal detachment)?

YES NO If yes, please explain: _____

Do you **smoke**? YES NO If yes, how much? _____

Do you drink **alcohol**? YES NO If yes, how much? _____

Physician Signature: _____

Date: ____/____/____

Reviewed: ____/____/____ Patient Initials: _____ Physician Signature: _____

____/____/____ Patient Initials: _____ Physician Signature: _____

____/____/____ Patient Initials: _____ Physician Signature: _____

____/____/____ Patient Initials: _____ Physician Signature: _____