PATIENT MEDICAL HISTORY RECORD

PATIENT'S NAME DATE

Medical Status and History:

Please answer the following questions:	YES	NO	If YES, Please explain
Have you ever been treated for any medical conditions? (e.g., diabetes, high blood pressure, arthritis, etc.)			
Have you ever had any eye disease? (e.g., glaucoma, cataract, lazy eye, retinal detachment, etc.)			
Have you had surgery? If YES, please list type of surgery and date			
Have you ever been hospitalized? If YES, please provide date and reason			
Do you take daily medications? If YES, please list medication name and dosage			
Do you use eye medications? If YES, please list medication name and dosage			
Do you have any DRUG allergies?			

Review of Systems:

Do you currently have any of the following problems?	YES	NO	If YES, Please explain
Chronic fever, unexplained weight loss/gain, fatigue			
Ear/nose/throat problems (hearing loss, sinus problems, sore throat)			
Heart problems (chest pain, irregular heartbeat, heart attack)			
Respiratory problems (shortness of breath, wheezing, coughing)			
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)			
Urinary problems (pain or discomfort, blood in urine)			
Skin problems (rashes, excessive dryness)			
Musculoskeletal problems (muscle aches, joint pain, swollen joints)			
Neurological problems (numbness, weakness, headaches, paralysis)			
Psychiatric problems (depression, anxiety)			

Family and Social History:

Please answer the following questions:	YES	NO	If YES, Please explain
Do any medical or eye diseases run in your family? (Diabetes, high blood pressure, cancer, glaucoma, macular degeneration)			
Do you smoke? If YES, how much?			
Do you drink alcohol? If YES, how much?			

Comments:

MD/OD Signature Date