ADULT OPHTHALMOLOGY MEDICAL HISTORY

INSTRUCTIONS Please provide as much information as possible. This will enable our medical team to expedite the collection of your medical history.

PATIENT ID _____

DATE _____

LAST NAME _____

FIRST NAME _____

DATE OF BIRTH _____ **AGE** _____

REFERRING DOCTOR _____

PRIMARY DOCTOR _____

Describe the problem you are having with your eyes

_____
_____
_____
_____

Do you have or have you ever had:

		Describe Briefly
Diabetes Mellitus	**YES_____NO____**	_____
Heart Disease	**YES_____NO____**	_____
High Blood Pressure	**YES_____NO____**	_____
High Cholesterol/triglycerides	**YES_____NO____**	_____
Stroke	**YES_____NO____**	_____
Seizures	**YES_____NO____**	_____
Emphysema or bronchitis	**YES_____NO____**	_____
Liver disease or Jaundice	**YES_____NO____**	_____
Hepatitis	**YES_____NO____**	_____
Kidney disease	**YES_____NO____**	_____
Skin problems	**YES_____NO____**	_____
Arthritis	**YES_____NO____**	_____
Cancer	**YES_____NO____**	_____
Thyroid disease	**YES_____NO____**	_____
Bleeding disorder	**YES_____NO____**	_____
Migraine headaches	**YES_____NO____**	_____
Depression/psychiatric disorder	**YES_____NO____**	_____
Problems with anesthesia	**YES_____NO____**	_____

Are you allergic to any medications **YES_____NO____**

If yes, what drug(s) _____
_____
_____

Do you have seasonal allergies **YES____NO____**

Do you or have you ever smoked **YES____NO____**

If yes, number of cigarettes smoked per day _____

I quit _____years ago

Do you drink alcohol **YES____NO____**

If yes, how much per week _____

Are you currently taking any medicines **YES____NO___**

If yes, please list the name of the medicine and the dosage.

NAME OF MEDICINE	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had eye surgery **YES____NO____**
If yes, please list the approximate date of surgery and left/right or both eyes.

TYPE OF SURGERY	DATE	EYE (L/R or BOTH)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any other type of surgery in the past YES ___ NO___
If yes, please list the approximate date of surgery and type.

TYPE OF SURGERY	DATE
_____	_____
_____	_____
_____	_____

Does any member of your immediate family have any of the following eye diseases

Glaucoma	YES_____NO____
Blindness	YES_____NO____
Retinal detachment	YES_____NO____
Strabismus (crossed eyes)	YES_____NO____
Amblyopia (lazy eye)	YES_____NO____

Do you currently have any of the following health problems?

Chest Pain	YES_____NO____
Shortness of Breath	YES_____NO____
Cough	YES_____NO____
Fever	YES_____NO____
Nausea	YES_____NO____
Night Sweats	YES_____NO____
Diarrhea	YES_____NO____
Stomach Problems	YES_____NO____
Sores in the mouth or on the genitals	YES_____NO____
Joint Pain	YES_____NO____
Hearing Loss	YES_____NO____
Ringing in the ears or dizziness	YES_____NO____
Rashes on the skin	YES_____NO____
Bruises, bleeding from the gums or nose	YES_____NO____
Excessive sensitivity to the heat and/or cold	YES_____NO____
Muscle Weakness	YES_____NO____
Recent Weight Loss	YES_____NO____
Headache	YES_____NO____
Jaw spasm when chewing	YES_____NO____

Comments _____

_____

_____

_____