

MEDICAL HISTORY



Affix Patient Label Here

**Reason for visit:**

Chief complaint: (briefly describe the main problem; your doctor will obtain additional details)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you need your glasses checked or replaced?  YES  NO

List major illnesses  
(hypertension, diabetes, heart disease, cancer)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications:

Drug Dose (if known)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List major surgery or hospitalization

Surgical type Year

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies (medications):

Drug Type of reaction (e.g. rash)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Please indicate if you have any family history of the following?*

**FAMILY HISTORY**

**Relationship**

**SOCIAL HISTORY**

Blindness		Do you smoke? <span style="float: right;">[Yes] [No]</span>
Glaucoma		Packs per day?
Cancer		How many years have you smoked?
Heart Disease/Heart Attack		Do you drink alcohol? <span style="float: right;">[Yes] [No]</span>
Diabetes		How frequently do you drink?
Stroke		
Other disorders (list in the explanation box)		

# REVIEW OF SYMPTOMS AND FAMILY HISTORY

*Please check off any applicable symptoms or problems; your physician will obtain additional details if necessary.*

*If you have no problems in a specific area please indicate by checking off the "no" box*

*Briefly explain any checked box (if necessary).*

<b>Review of Ophthalmological Symptoms</b>				
<b>EYES</b>	<b>YES</b>	<b>NO</b>	<b>DETAILS</b>	
Loss of vision				
Blurred vision				
Fluctuating Vision				
Distorted vision (halos)				
Glare or Light sensitivity				
Loss of side vision				
Double vision				
Dryness				
Mucous Discharge				
Redness				
Sandy or gritty feeling				
Itching				
Burning				
Foreign Body sensation				
Excess tearing or watering				
Eye pain or soreness				
Infection of eye or eyelid				
Tired eyes				
Crossed eyes, lazy eye				
Drooping eyelid				
Other				
<b>General Medical History</b>				
<b>CONDITION</b>	<b>YES</b>	<b>NO</b>		<b>DETAILS</b>
<b>GENERAL</b> Fever, Night sweats, Weight loss, fatigue				
<b>EAR , NOSE, THROAT</b> Sinus, otitis, hearing loss, ringing in the ears, vertigo, other				
<b>CARDIOVASCULAR</b> Heart attacks, cholesterol problems, shortness of breath, high blood pressure, heart murmur, chest pains, palpitations, rheumatic fever				
<b>RESPIRATORY</b> shortness of breath, asthma, wheezing, cough, pain with breathing, emphysema, other				
<b>PSYCHIATRIC</b> Anxiety, depression, insomnia, other				
<b>GASTROINTESTINAL</b> Colitis, ulcers, rectal bleeding, diarrhea, nausea, vomiting, other				
<b>KIDNEY, BLADDER, GENITALS</b> Blood in urine, frequent urination, painful urination, renal failure, dialysis, other				
<b>MUSCLES, JOINTS, BONES</b> Arthritis, joint pains, fractures, disc problems, other				
<b>SKIN</b> Skin cancer, rashes, itchiness, moles, other				
<b>NEUROLOGICAL</b> Numbness, tingling of arms or legs, weakness, vertigo, gait, balance, coordination, speech problems, loss of consciousness, blind spots in vision, headaches, migraine.				
<b>HORMONAL/ENDOCRINE</b> Abnormal menstrual cycle, diabetes, thyroid problems, pituitary problems				
<b>BLOOD</b> Bleeding problems, anemia, blood loss, transfusions in the past, other				
<b>OTHER</b>				

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Technician Initials:** \_\_\_\_\_