Patient Medical History Record

Patient's Name ______________________ Birth Date ______________________ Date ______________________

Past Medical History

1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, heart disease, arthritis, etc)?

If YES, please explain: ____

2. Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?

If YES, please explain: ____

3. List ALL surgeries: ____

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4. List all MEDICATIONS ____

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5. List DRUG ALLERGIES: ____

Review of Systems Do you currently have any of the following problems?	Yes	No	Please explain:
Chronic fever, unexpected weight loss/gain, fatigue…	☐	☐	____________
Ear/nose/throat (e.g. hearing loss, sinus problems, sore throat)	☐	☐	____________
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	____________
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	☐	☐	____________
Gastrointestinal problems (e.g. abdominal pain, diarrhea, vomiting)	☐	☐	____________
Urinal problems (e.g. pain or discomfort, blood in urine)	☐	☐	____________
Skin problems (e.g. rashes, excessive dryness)	☐	☐	____________
Musculoskeletal problems (e.g. muscle aches, joint pain or swelling)	☐	☐	____________
Neurologic problems (e.g. weak/numbness, headaches, paralysis)	☐	☐	____________
Psychiatric problems (e.g. depression, anxiety)	☐	☐	____________

Family and Social History

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

If YES, please explain: ____

Do you SMOKE? Yes ☐ No ☐ How much? ____________

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For office use only. DO NOT write below this line.

Reviewed by ____________ Date ____________ No changes Updated ____________
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