Medical History

(Please Print)

Patient's Name: ______________________________ Age: _____ Sex: _______

Primary Care Physician: _________________________

1. Are you currently experiencing any eye symptoms? Please circle all that apply:

Eye Pain	Blurred Vision	Eyelid Crusting	Flashes of Light
Halos	Red Eyes	Light Sensitivity	Double Vision
Floaters	Discharge	Eye Pressure	Foreign Body Sensation

2. Please circle any of the following you would like more information about:

Laser Vision Correction	Cataract Surgery	Diabetic Eye Disease
Glaucoma	Macular Degeneration	Other: ___________

3. Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)
   Yes ☐ No ☐ If YES, please explain: ______________________________________
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment, eye injury)
   Yes ☐ No ☐ If YES, please explain: ______________________________________
3. Have you ever had any eye surgery?
   Yes ☐ No ☐ If YES, please explain: ______________________________________
4. Have you ever been hospitalized?
   Yes ☐ No ☐ If YES, Please provide reason: __________________________________
5. Do you take any medications?
   Yes ☐ No ☐ If YES, Please list: ____
6. Do you take any eye medications:
   Yes ☐ No ☐ If YES, Please list: ____
7. Do you have any drug or food allergies?
   Yes ☐ No ☐ If YES, Please list: ____

Review of Systems

Do you currently have any of the following problems:	YES	NO	If YES please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	____________________
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	☐	☐	____________________
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	____________________
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	____________________
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea)	☐	☐	____________________
Urinary problems (e.g., pain discomfort, blood in urine)	☐	☐	____________________
Skin problems (e.g., rashes, excessive dryness)	☐	☐	____________________
Musculoskeletal problems (e.g., muscle aches, joint pain)	☐	☐	____________________
Neurological problems (e.g., numbess, weakness, 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)
Yes ☐ No ☐ If YES, please explain: ____

Do you smoke? If yes, how much? ____ Drink alcohol? If yes, how much? ____

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M.D. Signature Date