eye surgical associates

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ADULT MEDICAL HISTORY

Name: _____ Date: _____

Please list current and past **MEDICAL PROBLEMS**: (please print)

_____

_____

_____

List any **SURGERIES** you have had and when:

_____

_____

_____

Please circle current or past **EYE PROBLEMS**:

Cataracts Glaucoma Macular Degeneration Dry Eye

Retinal Detachment Crossed/Misaligned eyes Lazy Eye/Amblyopia

List OTHER current and past EYE PROBLEMS (include **EYE SURGERY AND INJURIES**):

_____

_____

_____

List current **MEDICATIONS** and the medical problem for which you take them (prescription and non-prescription):

_____

_____

_____

List current **EYE DROPS** (prescription and non-prescription):

_____

_____

_____

List Drug **ALLERGIES**:

_____

_____

Personal Health Habits: (Circle the most appropriate)

Do you smoke? yes no quit If yes, how much? _____
Do you drink alcohol? yes no If yes, how often? Rarely Occasionally Daily

Date of last eye exam: _____ Doctor: _____

TURN PAGE OVER CONTINUED ON BACK

Complete both sides of this form

FAMILY MEDICAL HISTORY:
List any RELATIVE with any of the following problems:
Heart Disease: _____ Cancer: _____
High Blood Pressure:_____ Diabetes: _____
Arthritis:_____ Lung Disease: _____
Other Inherited diseases:_____

FAMILY EYE HISTORY:
List any RELATIVE with any of the following problems:
Cataracts: _____ Glaucoma: _____
Macular Degeneration: _____ Dry Eye: _____
Retinal Detachment: _____ Misaligned Eyes: _____
Lazy Eye/Amblyopia: _____ Other: _____

PATIENT REVIEW OF SYSTEMS: (please circle Y=yes N=no)

GENERAL			**RESPIRATORY**			**URINARY**		
WEIGHT LOSS OR GAIN	Y	N	SHORTNESS OF BREATH	Y	N	PAIN WHILE URINATING	Y	N
FATIGUE	Y	N	COUGH	Y	N	BLOOD IN URINE	Y	N
FEVER	Y	N	WHEEZING	Y	N	URINARY TRACT INFECTION	Y	N
OTHER			OTHER			OTHER		
EAR, NOSE THROAT			**GASTROINTESTINAL**			**PSYCHIATRIC**		
HEARING LOSS	Y	N	HEARTBURN	Y	N	ANXIETY	Y	N
SORE THROAT	Y	N	ABDOMINAL PAIN	Y	N	DEPRESSION	Y	N
SINUS PROBLEMS	Y	N	DIARRHEA	Y	N	OTHER		
OTHER	Y	N	VOMITING	Y	N	**HEMATOLOGY**		
SKIN			BLOOD IN STOOL	Y	N	ANEMIA	Y	N
RASH	Y	N	OTHER			BRUISE EASILY	Y	N
DRY SKIN	Y	N	**MUSCULOSKELETAL**			TRANSFUSION	Y	N
SKIN CANCER	Y	N	MUSCLE ACHES	Y	N	OTHER		
OTHER			JOINT PAIN	Y	N	**IMMUNE SYSTEM DISEASES**	Y	N
HEART			JOIN SWELLING	Y	N			
CHEST PAIN	Y	N	OTHER					
MURMUR	Y	N	**NEUROLOGICAL**					
IRREGULAR HEARTBEAT	Y	N	HEADACHES	Y	N			
OTHER			NUMBNESS	Y	N			
			EXTREMITY WEAKNESS	Y	N			
			DIZZINESS	Y	N			
			OTHER					

This information is a valuable part of our medical record. Thank you for spending the time to complete the questions.

REVIEWED BY _____ DATE _____