Patient Medical History Record

Name: ______________________________ Date of Birth: __________ Date: ___________

REVIEW OF SYSTEMS (List past and present information)

Do you have any of the following conditions or problems?	YES	NO	If yes, please explain
Constitutional (fever, weight loss/gain, fatigue, etc.)	☐	☐	____________
Ear/Nose/Throat (hearing loss, sinus problems, sore throat)	☐	☐	____________
Cardiovascular (high blood pressure, heart problems, etc.)	☐	☐	____________
Endocrine (diabetes, thyroid problems, Grave's disease)	☐	☐	____________
Hematological/Lymphatic (AIDS, HIV+, hepatitis, high cholesterol)	☐	☐	____________
Respiratory (asthma, emphysema, bronchitis, tuberculosis)	☐	☐	____________
Gastrointestinal (heartburn, ulcer, abdominal pain)	☐	☐	____________
Genitourinary (genital, kidney, bladder problems)	☐	☐	____________
Integumentary (rashes, rosacea, dry skin, breast problems)	☐	☐	____________
Musculoskeletal (arthritis, lupus, gout, osteoporosis)	☐	☐	____________
Neurological (headaches, stroke, multiple sclerosis, paralysis)	☐	☐	____________
Psychiatric (depression, anxiety)	☐	☐	____________
Allergic/Immunologic (seasonal allergies, hay fever)	☐	☐	____________
Have you ever had any surgery (not including eyes)?	☐	☐	____________
Have you ever had any injuries?	☐	☐	____________
Are you ALLERGIC to any medications?	☐	☐	____________

FAMILY HISTORY	YES	NO	WHO
Blindness	☐	☐	__________
Diabetes	☐	☐	__________
Glaucoma	☐	☐	__________
Macular Degeneration	☐	☐	__________
Retinal Detachment	☐	☐	__________
High Blood Pressure	☐	☐	__________
Heart Disease	☐	☐	__________
Cancer	☐	☐	__________
Alzheimers	☐	☐	__________

Other: ______________________________

SOCIAL HISTORY	YES	NO	How Much
Do you smoke?	☐	☐	______
Do you drink alcohol?	☐	☐	______
Do you exercise?	☐	☐	______

EYE HISTORY	YES	NO	
Do you wear glasses?	☐	☐	
Do you wear contact lenses?	☐	☐	☐ Soft ☐ Hard
Do you have any history of eye disease, injury, or illness?	☐	☐	____________
Have you ever had surgery on your eyes?	☐	☐	____________
Are you currently taking any eye medication?	☐	☐	____________
Are you currently taking ANY medications?	☐	☐	____________

(If yes, please list)

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Physicians Signature ______________________________ Date __________