NEW PATIENT MEDICAL HISTORY

Who is your primary care physician?
Name_____
Address_____
_____

Who referred you to see us?
Name_____
Address_____
_____

PAST EYE HISTORY

Have you ever had any eye injuries in the past? Yes No
Did this injury require treatment? Yes No
Did you lose vision as a result of the injury? Yes No
Please describe the injury:_____
_____
_____

Were you diagnosed with any eye problems in infancy or childhood such as "lazy eye" (amblyopia), an in-turning or out-turning eye (strabismus), retinal disease from premature birth (ROP) or any inherited eye abnormalities? Yes No
Did this problem require treatment? Yes No
Please describe the problem and treatment_____
_____
_____

Do any eye diseases run in your family such as macular degeneration, glaucoma or other inheritable conditions? Yes No
Please list them:_____
_____
_____

Do you wear glasses or contacts? Yes No
If no, did you wear glasses or contacts in the past? Yes No

What eye conditions do you currently have (such as glaucoma, cataract, diabetic eye disease, macular degeneration)? Please list them below and the approximate year you were diagnosed with the condition.

Name of condition	Year diagnosed
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(CONTINUED NEXT PAGE)

Please list below any eye surgeries or LASER treatments that you have had. Give the name of the surgeon and the approximate year of the procedure. (For example, glaucoma surgery, cataract surgery or LASER treatment for diabetes)

Type of surgery	Surgeon	Year performed

Please list below any drops, ointments or other medicines you are taking for your eyes.

Past Medical History:

Please list below any medical conditions with which you have been diagnosed. Also give the approximate year of diagnosis and who is currently treating the problem (if different from your primary physician listed above).

☐ None

Name of condition	Treating physician	Year diagnosed

If you have diabetes,

- When were you diagnosed?
- Do you use insulin? Yes No
- Has your blood sugar been difficult to control? Yes No
- Has the diabetes caused any damage to your kidneys, heart or feet? Yes No

Have you ever been diagnosed with Graves' disease or other thyroid problems? Yes No

If you have had a stroke?

- Did you lose vision as a result? Yes No
- Did the stroke affect the movement of your eyes? Yes No

Have you ever been diagnosed with multiple sclerosis or optic neuritis? Yes No

Have you been diagnosed with myasthenia gravis? Yes No

Have you ever been diagnosed with autoimmune problems such as lupus, Sjogren's syndrome, rheumatoid arthritis, Reiter's syndrome, Behcet's disease or ankylosing spondylitis? Yes No

Please list hospitalizations below (please give the year and reason):

_____
_____
_____
_____
_____
_____
_____

List your current medications.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all non-eye surgeries below.

Type of surgery	Surgeon	Year performed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any drug allergies? (Give the name and describe the reaction below.)

_____
_____
_____

FAMILY & SOCIAL HISTORY

Please list any family medical problems such as diabetes, cancer or heart disease below.

Family Member	Name of Condition or cause of death
_____	_____
_____	_____
_____	_____
_____	_____

How much alcohol or tobacco do you currently use?
Alcohol_____
Tobacco_____

Do you use any street drugs?
Type_____

Do you live ☐alone ☐with family ☐assisted living ☐Other _____
Are you ☐single ☐married ☐widowed ☐divorced
What type of work do you do? _____
Who is your employer? _____

(CONTINUED NEXT PAGE)

REVIEW OF SYSTEMS: Please check any of the following that apply to you

GENERAL SYMPTOMS
- ❑ Good general healthy lately
- ❑ Recent unplanned weight change
- ❑ Decreased appetite
- ❑ Fever or night-sweats
- ❑ Fatigue, weakness or falling
- ❑ Obesity

ALLERGIC/IMMUNOLOGIC ☐N/A

History of skin reaction or other adverse reaction to:
- ❑ Penicillin or other antibiotics
- ❑ Morphine, Demerol or other narcotics
- ❑ Novocaine or other anesthetics
- ❑ Aspirin or other pain remedies
- ❑ Tetanus antitoxin or other serums
- ❑ Iodine, merthiolate or other antiseptic
- ❑ Other drugs/medications:_____

Known food allergies:_____

Environmental allergies:_____

CARDIOVASCULAR ☐N/A
- ❑ Heart problems or chest pain
- ❑ Palpitation or irregular heart beat
- ❑ Shortness of breath with walking
- ❑ Shortness of breath at rest or when lying flat
- ❑ Swelling in ankles, feet or hands

EARS/NOSE/THROAT ☐N/A
- ❑ Hearing loss or ringing
- ❑ Earaches or drainage
- ❑ Chronic sinus problems
- ❑ Nose bleeds
- ❑ Mouth sores
- ❑ Sore throat or voice change

ENDOCRINE ☐N/A
- ❑ Hormone or "gland" problem
- ❑ Thyroid disease
- ❑ Heat or cold intolerance
- ❑ High cholesterol
- ❑ Diabetes
- ❑ Excessive thirst or urination

GASTROINTESTINAL ☐N/A
- ❑ Change in bowel movements
- ❑ Nausea or vomiting
- ❑ Frequent diarrhea
- ❑ Painful bowel movements or constipation
- ❑ Rectal bleeding or blood in stool
- ❑ Abdominal/belly pain
- ❑ Ulcers

GENITOURINARY ☐N/A
- ❑ Frequent urination or awaken at night to urinate
- ❑ Burning or painful urination
- ❑ Blood in urine
- ❑ Incontinence or dribbling
- ❑ Sores or discharge
- ❑ Kidney stone
- ❑ Sexual difficulty
- ❑ Male – testicle pain/lumps
- ❑ Male – discharge from or sores on penis
- ❑ Female – painful or irregular periods
- ❑ Female – prior abnormal pap smear
- ❑ Female – vaginal discharge

Female – number of pregnancies_____

Female – number of miscarriages:_____

Female – date of last pap smear_____

HEMATOLOGIC/LYMPHATIC ☐N/A
- ❑ Slow to heal after cuts
- ❑ Bleeding or bruising tendency
- ❑ Anemia
- ❑ Blood clots
- ❑ Blood transfusion
- ❑ Enlarged glands

INTEGUMENTARY ☐N/A
- ❑ Rash or itching
- ❑ Change in skin color
- ❑ Change in hair or nails
- ❑ Varicose veins
- ❑ Breast lump or pain
- ❑ History of abnormal mammogram

MUSCULOSKELETAL ☐N/A
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Weakness of muscles or joints
- ❑ Muscle pain or cramps
- ❑ Back pain
- ❑ Difficulty in walking
- ❑ History of bone fracture

NEUROLOGIC ☐N/A
- ❑ Frequent or recurring headaches
- ❑ Light-headed or dizzy
- ❑ Convulsions or seizures
- ❑ Numbness or tingling sensation
- ❑ Shakes
- ❑ Paralysis
- ❑ Stroke
- ❑ Head injury

OCULAR ☐N/A
- ❑ Eye disease or injury
- ❑ Wear glasses or contact lenses
- ❑ Blurred or double vision
- ❑ Glaucoma or cataracts

PSYCHIATRIC ☐N/A
- ❑ Memory loss or confusion
- ❑ Nervous or anxious
- ❑ Worry about job, money, children or marriage
- ❑ Depression, frequent crying or easily upset
- ❑ Difficulty sleeping

PULMONARY ☐N/A
- ❑ Chronic or frequent cough
- ❑ Exposure to tuberculosis or active tuberculosis
- ❑ Spitting up blood
- ❑ Shortness of breath
- ❑ Asthma or wheezing

Other_____

Reviewed by:_____M.D. Date: _____/_____/_____