PATIENT MEDICAL HISTORY FORM

(To be completed by Patient)

Name _____ **Date** _____

Ocular History

Complaints	NO	YES
Dry Eyes	☐	☐
Retinal Detachment	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Eye Injury	☐	☐
Other _____		

Eyes/Review of Systems

Complaints	NO	YES
Loss of Vision	☐	☐
Redness	☐	☐
Tearing	☐	☐
Burning	☐	☐
Discharge	☐	☐
Diplopia (Double vision)	☐	☐

Medical History

Please list systemic illnesses, previous surgeries (including eye), and/or hospitalizations **Date**

_____ _____

_____ _____

_____ _____

Review of Symptoms

	NO	YES
Constitutional		
Fever	☐	☐
Weight Loss	☐	☐
Cardiovascular		
Chest Pain	☐	☐
Heart Disease	☐	☐
Respiratory		
Asthma	☐	☐
Emphysema	☐	☐
Gastrointestinal		
GI Bleeding	☐	☐
Integumentary		
Skin Cancers	☐	☐
Previous Skin Peels	☐	☐
Allergy/Immune		
HIV	☐	☐
Other _____		
_____		

Pertinent = 1 Sys Reviewed

Extended = 2-9 Sys Reviewed

Complete = 10+ Sys Reviewed

	NO	YES
Musculoskeletal		
Arthritis	☐	☐
Muscular Dystrophy	☐	☐
Neurologic		
Strokes	☐	☐
Bell's Palsy	☐	☐
Neurologic Illness	☐	☐
Psychiatric		
Depression	☐	☐
Anxiety	☐	☐
Endocrine		
Thyroid Disease	☐	☐
Heme-Lymph		
Hepatitis	☐	☐
Other Systemic Illness		
_____		
Obstretical		
Are you Pregnant?	☐	☐

Social History

Alcohol Intake Per Day (including wine, beer, mixed drinks) _____

Smoker _____ PPD ____ Years ____

Current Occupation _____

Household Lives Alone ____ Lives with Family ____ Other _____

Family Medical History (Do any members of your family have the following medical and/or ocular conditions?)

Medical	NO	YES
Diabetes	☐	☐
Cancer	☐	☐
Heart Disease	☐	☐
Thyroid Disease	☐	☐

Ocular	NO	YES
Ptosis (Droopy Lid)	☐	☐
Tear Duct Blockage	☐	☐
Other _____		

Tech Initials _____ Phys Signature _____