Eye Associates

PATIENT MEDICAL INFORMATION

Date: _____

Name: _____ Nickname: _____ Date of Birth: _____

Race: _____ Allergies: _____ PCP: _____

Other Doctors/ Referred By: _____ Pharmacy: _____

PATIENT MEDICATION LIST (including over-the counter)						
Medication/Drops	**Dosage**	**Times per Day**		**Medication/Drops**	**Dosage**	**Times per Day**

EYE HISTORY – Have you been diagnosed with any of the following?

YES	NO		YES	NO	
☐	☐	Cataracts _____	☐	☐	Eye Injury _____
☐	☐	Corneal Disease _____	☐	☐	Iritis/ Uveitis _____
☐	☐	Crossed Eyes/ Lazy Eye _____	☐	☐	Retina Disease _____
☐	☐	Glaucoma _____	☐	☐	Other Eye Disorders _____

Cataract Surgery (Date of Surgery) Right: _____ Left: _____

Other Eye Surgeries:

OTHER MEDICAL HISTORY – Have you been diagnosed with any of the following?

YES	NO		YES	NO	
☐	☐	Diabetes; ___ # of years? _____	☐	☐	Head or Spinal injuries _____
☐	☐	High Blood Pressure _____	☐	☐	HIV _____
☐	☐	Thyroid _____	☐	☐	Stroke _____
☐	☐	Heart Conditions _____	☐	☐	Arthritis _____
☐	☐	Pulmonary (i.e. asthma/emphysema, etc) _____	☐	☐	Abnormal lipids/Cholesterol _____
☐	☐	Cancer _____			

Other Medical Conditions and Surgeries (include date & type):

SOCIAL HISTORY

Current Occupation: _____ ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Do you drive? ___ Yes ___ No Use tobacco? __ Yes __ No If yes, amount? _____

Visual difficulty when driving? __ Yes __ No _____ Have you had a blood transfusion? __ Yes __ No

Drink alcohol? __ Yes __ No If yes, describe: _____ Recreational drugs? __ Yes __ No _____

FAMILY MEDICAL HISTORY – Do any blood relatives have any of the following? (describe relation to patient)

YES	NO		YES	NO	
☐	☐	Diabetes _____	☐	☐	Glaucoma _____
☐	☐	Diabetic Retinopathy _____	☐	☐	Macular Degeneration _____
☐	☐	Cancer _____	☐	☐	Heart Disease _____

Other Eye and Relevant Diseases:

Eye Associates

PATIENT MEDICAL INFORMATION

Date: _____

Name: _____ Nickname: _____ Date of Birth: _____

Height:____ Weight: _____ Sex: Male / Female

Review of Systems		
CONDITIONS:	**Circle any and all conditions that apply to you or check none.**	**Check (if None)**
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches	
SKIN, NAILS, HAIR	rashes, itching, dryness, color changes, suspicious growth, acne, rosacea, melanoma	
EARS, NOSE, MOUTH, THROAT:	hard of hearing, wearing hearing aids, earache, vertigo, stuffiness, discharge, itching, hay fever	
RESPIRATORY:	cough, coughing up blood, shortness of breath, wheezing, painful breathing, asthma, emphysema, COPD	
CARDIOVASCULAR:	Chest pain or discomfort, tightness, palpitations, swelling, difficulty breathing while lying down, hypertension, sudden awakening w/ shortness of breath, calf pain with walking, leg cramping, hypertension, cardiovascular disease, AFIB, aortic valve replacement, carotid artery disease	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD, change in appetite, change in bowel habits, rectal bleeding	
GENITOURINARY:	painful/ frequent urination, impotence, yellow jaundice, kidney stones, blood in urine, prostate disorder or cancer (males), UTI	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
NEUROLOGICAL:	numbness, dizziness, fainting, seizures, tremors, paralysis, stroke, dementia, memory loss, brain tumor, multiple sclerosis	
PSYCHIATRIC:	anxiety, depression, stress, hallucinations, schizophrenia, ADD	
ENDOCRINE:	diabetes, excessive sweating, hypothyroid, hyperthyroid, hormone, increased thirst, Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	bleeding, anemia, blood clots, problems related to blood transfusions	
ALLERGIC/ IMMUNOLOGIC:	environmental allergies, reduced immunity, autoimmune disorder	
CANCER:	breast, prostate, lung, skin, colon , other	