Medical History

Since your last visit to our office, we have implemented electronic health records in our practice. Electronic health records are designed to increase quality of care, and ultimately, improve efficiency of care between providers. To that end, we will be changing some of our procedures, and asking health questions that may seem unusual compared to your previous eye exams. We appreciate your patience and cooperation during this transition to better patient care.

Name: _____ Primary care physician: _____

Spouse: _____ Child's Parent or Guardian: _____

Race: ___ White ___ American Indian or Alaskan Native ___ Asian ___ Black or African American
___ Native Hawaiian or other Pacific Islander ___ Other Race ___ Unknown

Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino

Current Medications: (Rx and Over the Counter) or present list

_____

_____

_____

_____

_____

_____

Allergies (Medical and other):

_____

_____

_____

_____

_____

_____

Personal History/Review of Systems (circle all that are appropriate) – check here if none apply ( )

Constitution
Fatigue syndrome
Cancer
Developmental disabilities
Other

Cardiovascular
Congestive heart failure
Vascular disease
Heart disease
Stroke
Hypertension
Other

Musculo-skeletal
Muscular dystrophy
Ankylosing spondylitis
Osteoporosis
Gout
Fibromylagia
Osteoarthritis
Arthritis
Other

Ears/Nose/Throat
Hearing loss
Dry mouth
Sinusitis
Other

Respiratory
Asthma
Bronchitis
Emphysema
Chronic obstruction
Sleep apnea
Other

Integumentary (Skin)
Herpes zoster/shingles
Herpes simplex/cold sores
Eczema
Psoriasis
Rosacea
Other

Nervous System
Multiple sclerosis
Cerebral palsy
Epilepsy
Stroke/CVA
Migraine/Headache
Tumor
Other

Gastroinstestinal (GI)
Colitis
Crohn's disease
Celiac disease
Acid reflux
Ulcer
Other

Endocrine
Hormonal dysfunction
Thyroid dysfunction
Type 1 diabetes mellitus
Type 2 diabetes mellitus
Other

Psychiatric
Anxiety disorder
Bipolar disorder
Depression
Attention deficit
Other

Genitourinary (GU)
Chlamydia
Herpes
Nursing
Pregnant
STD-herpetic/chlamydia
Benign prostate hypertrophy
Kidney disease
Prostate disease/cancer

Hematological (Blood/lymph)
Anemia
Large volume blood loss
Ulcer
High cholesterol
Other

Allergy/Immunologic
Lupus
Rheumatoid arthritis
Sjogren's syndrome
Other

Eyes
Injury
Dry eye
Retinal detachment
Keratoconus
Glaucoma
Cataracts
Surgery
Strabismus
Amblyopia
Patching
Retinal degeneration/hole
Macular degeneration
Nystagmus
Other

Family medical history: Circle appropriately, or: ( ) none of the following
Diabetes Hypertension Thyroid Cancer Other

Family ocular history: Circle appropriately, or: ( ) none of the following
Cataracts Amblyopia Macular degeneration Glaucoma
Retinal detachment Strabismus Dry Eye Nystagmus

Social history: Do you drive? Y / N
Do you consume alcohol? Y / N Social / Regular / Frequent
Smoking Status: ____ Never smoked _____ Former smoker
____ Current some day smoker ____ Current every day smoker

Hobbies: _____

_____

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