Welcome To Our Office

Medical History Record

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

 First MI Last

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently wear glasses? □ Yes □ No \_\_\_ Prog \_\_\_Bif \_\_\_Trif \_\_\_SV \_\_\_Readers

Do you currently wear contacts? □ Yes □ No \_\_\_Disp \_\_\_SV \_\_\_Multif \_\_\_GP \_\_\_Monovison

What is the purpose of your visit today? No Vision Issues 🞎 Problem 🞎

if so please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently having any Headaches \_\_Y\_\_N, Flashes \_\_Y\_\_N, Floaters \_\_Y\_\_N,

Redeye \_\_Y \_\_N, Abrasions \_\_Y\_\_N, Allergy \_\_Y \_\_N, Foreign Body \_\_Y \_\_N,

Lumps/Lesions \_\_Y \_\_N, Pain \_\_Y \_\_N

Ask them to bring their list of medications with Dosage and how they are taken.

List all medications, dosage & reason for taking: (Prescription and Over-the-Counter) Attach list if necessary.

|  |  |  |  |
| --- | --- | --- | --- |
| (Name & Dosage)Medications | (Reason for taking) | (Name & Dosage)Occular Meds | (Reason for taking) |
| (1) |  | (1) |  |
| (2) |  | (2) |  |
| (3) |  | (3) |  |
| (4) |  | (4) |  |
| (5) |  | (5) |  |
| (6) |  | (6) |  |

Do you have allergies to any medications? Yes 🞎 NO 🞎 If YES, List medications and **reactions**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a Diabetic? Y \_\_ N\_\_ Type \_\_\_\_ 1 or \_\_\_2 What is your A1C \_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

**Do you presently have any problems in the following areas?**

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergic/Immunologic YES NO**Seasonal allergies 🞎 🞎 Immune problems 🞎 🞎 General allergies 🞎 🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­ | **Gastrointestinal YES NO****(Stomach/Intestines)**Jaundice/Hepatitis 🞎 🞎 Ulcers/Bleeding 🞎 🞎 Hiatus Hernia 🞎 🞎IBS 🞎 🞎Acid Reflux 🞎 🞎Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Integumentary YES NO****(Skin and/or Breast)**Psoriasis 🞎 🞎Acne Rosacea 🞎 🞎Lupus 🞎 🞎Other\_\_\_\_\_\_\_\_\_\_Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Respiratory YES NO****(Lungs/ Breathing)**Asthma 🞎 🞎Emphysema 🞎 🞎Tuberculosis 🞎 🞎Lung Cancer 🞎 🞎Sarcoidosis 🞎 🞎COPD 🞎 🞎Cystic Fibrosis 🞎 🞎Other\_\_\_\_\_\_\_\_ |
| **Cardiovascular YES NO**Congestive heart failure 🞎 🞎Heart murmur 🞎 🞎Heart attacks 🞎 🞎Heart Palpations 🞎 🞎Blood pressure 🞎 🞎Chest pain/angina 🞎 🞎Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Genitourinary YES NO****(Genitals/Kidney/Bladder)**Kidney disease 🞎 🞎Kidney Stones 🞎 🞎Other\_\_\_\_\_\_\_\_\_\_\_Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Musculo-Skeletal YES NO**Degenerative arthritis🞎 🞎Rheumatoid arthritis 🞎 🞎Muscle/ Joint pain 🞎 🞎Fibromyalgia 🞎 🞎Scoliosis 🞎 🞎Osteoporosis 🞎 🞎Other\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Constitutional Symptoms** **YES NO**Fever 🞎 🞎Weight Loss 🞎 🞎Fainting 🞎 🞎Dizziness 🞎 🞎Disorientation 🞎 🞎Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Head YES NO****(Ear, Nose, Mouth, Throat)**Hearing problems 🞎 🞎Sinus congestion 🞎 🞎Headaches 🞎 🞎Chronic cough 🞎 🞎Dry throat/mouth 🞎 🞎Other\_\_\_\_\_\_\_\_\_\_\_\_ | **Neurological YES NO**Migraines 🞎 🞎 Seizures🞎 🞎Stroke/Paralysis 🞎 🞎Vertigo 🞎 🞎Bell’s Palsy 🞎 🞎Epilepsy 🞎 🞎Multiple Sclerosis 🞎 🞎Muscular Dystrophy🞎 🞎Neurofibromatosis 🞎 🞎Other\_\_\_\_\_\_\_\_\_\_ |  |
| **Endocrine YES NO**Diabetes 🞎 🞎How Long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Reading\_\_\_\_\_\_\_\_\_\_Pancreatic Cancer 🞎 🞎Crohn’s Disease 🞎 🞎Thyroid Disorder 🞎 🞎Hormone Replacement 🞎 🞎Elevated Cholesterol 🞎 🞎Hyperthyroidism 🞎 🞎Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Hematologic/Lymphatic** **YES NO**Anemia 🞎 🞎Sickle Cell disease 🞎 🞎Leukemia 🞎 🞎Other\_\_\_\_\_\_\_\_\_\_\_\_Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Psychiatric YES NO**Depression 🞎 🞎Schizophrenia 🞎 🞎Bipolar 🞎 🞎ADD 🞎 🞎Alzheimer’s 🞎 🞎Anxiety Disorder 🞎 🞎Autism 🞎 🞎Dementia 🞎 🞎Other\_\_\_\_\_\_\_\_\_ |  |
|  |  |  |  |

**Past History**

List any major illneses and injuries you have had in the past:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_List any significant eye history (i.e.: cataracts, macular degeneration, glaucoma, injuries to eyes) you have had:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any surgeries you have had in the past including approximate date of surgery:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History (M=mother, F=father, B= brother, S= sister, MGP or PGP=grandparent)**

Patient Family If Family, what relation to you Patient Family If Family, what relation to you

 🞎 🞎 Glaucoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎 Hepatitis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞎 🞎 Lazy Eye\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎 HIV +/ AIDS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞎 🞎 Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎 Neurofibromatosis\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞎 🞎 High Blood Pressure­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎 Keratoconus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞎 🞎 Heart Disease\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎 Lyme disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 🞎 Sarcoidosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎 Graves Disease/Thyroid\_\_\_\_\_\_\_\_

 🞎 🞎 Asthma/ Breathing Problems\_\_\_\_\_\_\_ 🞎 🞎 Myasthenia Gavis\_\_\_\_\_\_\_\_\_\_\_\_\_

 🞎 🞎 Migraine Headaches\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎 Retinal Detachment\_\_\_\_\_\_\_\_\_\_\_\_

 🞎 🞎 Lupus\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎 Multiple Sclerosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 🞎 Cataracts\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎 Blindness­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* 🞎 Cataract Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 🞎 Retinitis Pigmentosa\_\_\_\_\_\_\_\_\_\_\_\_

🞎 🞎 Corneal Dystrophies\_\_\_\_\_\_\_\_\_\_\_\_

* 🞎 Macular Degeneration\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Do you smoke? □ Yes □ No If YES, How many packs a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you quit? □ Yes □ No How long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? □ Yes □ No If YES, How many drinks a day/ week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use narcotics drugs? □Yes □No

Have you ever had a sexually transmitted disease? □ Yes □ No

Have you ever had a blood transfusion? □ Yes □ No