PATIENT MEDICAL HISTORY RECORD

PATIENT NAME _____++_____ **DATE OF BIRTH** _____

PRIMARY CARE PHYSICIAN (full name) _____ **DATE COMPLETED** _____

ALLERGIES: ___ none If any, please list: _____

EYE HISTORY. Please circle any of the following that apply to your current vision correction:

Wear Glasses: single vision distance single vision readers bifocals progressive computer over-the-counter readers

Wear Contact Lenses: single vision mono vision (one eye distance/one eye near) multifocal Brand Name _____

Past Corrective Surgery with date(s): Lasik PRK Cataract Surgery with Intraocular Lens R L Both Eyes _____

Please circle / note below any other history of eye conditions or eye surgery/trauma that apply:

Cataract Glaucoma Macular Degeneration Retinal Detachment Dry Eye Corneal Dystrophy Lazy Eye Retinopathy Iritis Keratoconus Other _____

Past Eye Surgery/Laser or Trauma with Dates: _____

REVIEW OF SYSTEMS. Please circle below any of the following symptoms / medical issues that apply to your personal past or current medical history; including any treated, untreated or borderline conditions, and any type of cancer that has been diagnosed.

CONSTITUTIONAL: Fever Weight Changes Fatigue Other _____

CARDIOVASCULAR: High Blood Pressure High Cholesterol Heart Attack Stroke By-pass Surgery Pacemaker Stents Carotid Disease Congestive Heart Failure Angioplasty Atrial Fibrillation Other _____

GENITOURINARY: Urinary/Kidney Disorder Prostate Disorder PCOS Other _____

NEUROLOGICAL : MS Parkinson's Headaches Neuropathy ALS Seizures Other _____

PSYCHIATRIC: Depression Anxiety Bipolar Schizophrenia Dementia Other _____

RESPIRATORY: Sarcoidosis COPD Asthma Emphysema Sleep Apnea Other _____

INTEGUMENTARY/BREAST: Rash Rosacea Psoriasis Eczema Malignancy Other _____

HEMATOLOGIC/LYMPHATIC: Anemia Leukemia Hepatitis HIV Lymphoma Other _____

ENDOCRINE: Diabetes (Type I /II /Pre) Hypothyroid Grave's disease Pituitary disorder Other _____

EARS/NOSE/MOUTH/THROAT: Hearing Loss Tinnitus Vertigo Nosebleeds Dry Mouth Other _____

GASTROINTESTINAL: Acid Reflux Pancreatic/Liver disease Crohn's Disease IBS Other _____

MUSCULOSKELETAL: Rheumatoid Arthritis Lupus Osteoporosis Myasthenia Gravis Other _____

ALLERGIC/IMMUNOLOGIC: Hayfever/Allergies Shingles Toxo/Histoplasmosis Sjogren's Other _____

Flu Shot Received? Yes No **last date** _____ **Pneumonia Vaccine Received?** Yes No **date(s):** _____

OTHER MEDICAL HISTORY NOT NOTED ABOVE:

PAST, FAMILY AND SOCIAL HISTORY.
Please indicate below the family members affected by the listed conditions:

Glaucoma _____

Macular Degeneration _____

Diabetes _____

Other _____

Please complete below:

Do you use tobacco products? Yes No

If so, how much? _____

Drink alcohol? Yes No

If so, how much? _____

Reviewed by Stephen M. Busch, D.O. _____ **Date:** _____ **Updated** _____ **Date:** _____