PATIENT MEDICAL HISTORY RECORD

PATIENT NAME _____ **DATE OF BIRTH** _____

PRIMARY CARE PHYSICIAN _____ **DATE COMPLETED** _____

PLEASE LIST BELOW ANY SPECIFIC ALLERGIES (medication, latex, food, environmental, etc.): or NONE ___

PLEASE LIST BELOW ANY MEDICATIONS USED ON A REGULAR BASIS (include *all* prescription or over-the-counter meds, vitamin supplements, topical creams or ointments, eye drops, etc.)

DO YOU WEAR PRESCRIPTION GLASSES? No Yes CONTACT LENSES? No Yes if yes, for distance__ reading__ both__

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

EYES: cataract glaucoma macular degeneration retinal detachment corneal dystrophy keratoconus lazy eye dry eye retinopathy strabismus iritis/episcleritis double vision baggy eyelids lid lesions/spider veins other _____

Please list any history of eye surgery, laser or trauma: _____

CONSTITUTIONAL: fever weight loss/gain fatigue trouble sleeping 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 polycystic ovary disease other _____

NEUROLOGICAL : multiple sclerosis Parkinson's headaches paralysis dizziness seizures other _____

PSYCHIATRIC: depression anxiety bipolar schizophrenia dementia other _____

RESPIRATORY: sarcoidosis pulmonary disease asthma emphysema sleep apnea other _____

INTEGUMENTARY/BREAST: rash rosacea psoriasis eczema malignancy other _____

HEMATOLOGIC/LYMPHATIC: anemia leukemia hepatitis HIV lymphoma other _____

ENDOCRINE: diabetes hypothyroid disease 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 other _____

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 smoke? Yes No

If so, how much? _____

Drink alcohol? Yes No

If so, how much? _____

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