**Pt Medical Status and History**

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Height: _____ Weight: _____

Last Eye Exam Date: _____ Location: _____

Are you pregnant? No ☐ Yes ☐ Maybe ☐ Are you currently breastfeeding? No ☐ Yes ☐

**WHAT IS THE MAIN REASON FOR YOUR APPOINTMENT TODAY?**

_____

_____

_____

_____

**HEALTH HISTORY**

**1. Have you ever had any eye disease or trauma (e.g. glaucoma, cataracts, lazy eye, retinal detachment)?** No ☐ Yes ☐ If Yes, please explain: _____

_____

**2. Have you ever had an eye surgery?** No ☐ Yes ☐

If Yes, please provide date and surgical procedure: _____

**3. Please list any current medications are you taking:** _____

_____

_____

_____

**4. Do you have any drug or medication allergies?** _____

**5. Have you ever had a surgery (not related to the eyes)?** No ☐ Yes ☐

If Yes, please provide date and surgical procedure: _____

_____

**FAMILY AND SOCIAL HISTORY**

**Does anyone in your family have/had an eye disease (e.g. glaucoma, cataracts, lazy eye)?**

No ☐ Yes ☐ If Yes, please explain: _____

_____

**For smoking, are you a:** Current Smoker ☐ Former Smoker ☐ Never Smoker ☐

**Current occupation:** _____ **Hobbies:** _____

**Do you work on a computer?** No ☐ Yes ☐ **How many hours per day?** _____

(Flip over for second page)

## REVIEW OF SYSTEMS (circle all that apply)

**Constitution**
All Negative
Fatigue
Sudden Weight Loss
Other: _____

**Cardiovascular**
All Negative
Angina Pectoris
Arrhythmia
Atrial Fibrillation
Atrioventricular Block
Cerebrovascular Disorder
Congestive Heart Failure
Heart Disease
Hypertension
Other: _____

**Ears, Nose, Mouth, Throat**
All Negative
Dizziness
Hearing Loss
Rhinitis
Sinusitis
Sinus Pain
Vertigo
Other: _____

**Respiratory**
All Negative
Asthma
Bronchitis
Emphysema
Sarcoidosis
Sleep Apnea
Other: _____

**Gastrointestional**
All Negative
Crohn's Disease
Hepatitis A, B, or C
Inflammatory Bowel Disease
Ulcerative Colitis
Other: _____

**Genitourinary**
All Negative
Dialysis
Kidney Failure
Kidney Stones
Other: _____

**Musculoskeletal**
All Negative
Arthritis
Behcet's Syndrome
Fibromyalgia
Giant Cell Arteritis
Juvenile Rheumatoid Arthritis
Polymyalgia Rheumatica
Sjogren's Syndrome
Spondyloarthropathies
Systemic Lupis Erythematosus
Other: _____

**Integumentary**
All Negative
Atopic Dermatitis
Basal Cell Carcinoma
Bruising
Eczema
Rosacea
Other: _____

**Neurological**
All Negative
Alzheimer's Disease
Bell's Palsy
Dementia
Headaches
Migraines
Stroke
Other: _____

**Psychiatric**
All Negative
Depression
Other: _____

**Endocrine**
All Negative
Diabetes - Borderline
Diabetes - Type 1
Diabetes - Type 2
Hyperthyroidism
Hypothyroidism
Pituitary Gland Disorders
Other: _____

**If you have Diabetes:**
For how many years:
Most recent HbA1C value is: ____
HbA1C was _____mos ago.

**Hematological / Lymphatic**
All Negative
Anemia
Hemophilia
Leukemia
Sickle Cell Disease
Spontaneuos Bleeding
Other: _____

**Allergic / Immunological**
All Negative
Anaphylaxis
Autoimmune Disorders
Drug Hypersensitivity
HIV / AIDS
Psoriatic Arthritis
Rheumatoid Arthritis
Other: _____

**Other History**
All Negative
Alcohol Dependence
Drug Dependence
Memory Loss
Significant Head Trauma
Other: _____