

MEDICAL HISTORY

Thank you for completing this form. This information will assist the doctors and staff in providing you with quality care.

Patient Name _____ Date: _____ Gender: M F

Height: _____ Weight: _____ Age: _____ DOB: _____

Race: Asian African American Caucasian Hispanic Native American Other: (Specify) _____

Are you pregnant? Yes No
Planning on it? Yes No

EYE HISTORY: Do you have problems with any of the following?

Driving when dark	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sewing & Threading a needle	<input type="checkbox"/> Yes <input type="checkbox"/> No
Driving into the sun	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reading medicine labels	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seeing highway signs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reading phone book	<input type="checkbox"/> Yes <input type="checkbox"/> No
Watery eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing details on TV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seeing a golf ball	<input type="checkbox"/> Yes <input type="checkbox"/> No	Computer screen blurry	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Blur as though your glasses are dirty or like looking through mist or cellophane?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reading newspaper, books or magazines	<input type="checkbox"/> Yes <input type="checkbox"/> No

How long have you had the most major of these problems? _____

Please list and describe some of your hobbies? _____

How much does your eye condition interfere with your activities/hobbies? _____

Please describe any other eye problems. _____

MEDICAL HISTORY: Have you or a family member had or do you currently have any of the following?

Systemic	Self	Family	Vascular	Self	Family
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clotting Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	Self	Family
Auto Immune Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Systemic Connective Tissue Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dermatitis/Eczema/Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prostate Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung	Self	Family	History of Keloid Scar Formation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	Self	Family
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you currently taking long term corticosteroids? Yes No

Any other diseases, conditions or problems we should know about? _____

SURGERY HISTORY: List ALL prior surgeries and year in the last 5 years: _____

FAMILY HISTORY: Have family members had serious eye problems? Yes No
If yes, please explain: _____

SOCIAL HISTORY:

Do you smoke? Yes No Packs per day? _____ For how many years? _____
Alcohol use? Yes No How much? _____ How Often? _____
Recreational drug use? Yes No Name of drug(s): _____

MEDICATION HISTORY:

Have you ever taken any alpha-blocker medications such as: Flomax (tamsulosin), Hytrin (terazosin), Cardura (doxazosin), Uroxatral (alfuzosin)? Yes No
Have you had problems with tranquilizers, narcotic medications or anesthetics? Yes No
If yes, what was the problem? _____
Have you recently taken Acutane, Cordarone or migraine medication? Yes No

PHARMACY INFORMATION:

Pharmacy Name: _____ Pharmacy phone number: _____

Pharmacy Address: _____

MEDICATIONS:

List all medications that you are currently taking, including over the counter medications or remedies (attach list if needed)

Drug Name	Strength	How Often

Drug Name	Strength	How Often

ALLERGIES & REACTIONS:

List all medication, food and other items that you are allergic to.
If you have no allergies, write "NONE"

PLEASE CHECK APPROPRIATE BOXES BELOW AND EXPLAIN:

<input type="checkbox"/> Yes <input type="checkbox"/> No	Fever or Fatigue?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Significant weight loss or gain?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Nose or throat problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have trouble hearing?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease, angina, fainting spells or fluid retention?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach or colon problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder or kidney problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain or stiffness?
<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV or hepatitis?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures or TIA's?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression, anxiety, mood disorder or memory loss?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding tendency?

Advanced Directive: If you have an advanced directive (i.e. Do Not Resuscitate order), it is your responsibility to provide our office with your written directive. If the need arises you will be transferred to the nearest hospital and the advanced directive on file will be given to them.

PATIENT PRINTED NAME

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

STAFF SIGNATURE

DATE