the eye clinic
surgicenter

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	☐ Yes ☐ No	Sewing & Threading a needle	☐ Yes ☐ No
Driving into the sun	☐ Yes ☐ No	Reading medicine labels	☐ Yes ☐ No
Seeing highway signs	☐ Yes ☐ No	Reading phone book	☐ Yes ☐ No
Watery eyes	☐ Yes ☐ No	Seeing details on TV	☐ Yes ☐ No
Seeing a golf ball	☐ Yes ☐ No	Computer screen blurry	☐ Yes ☐ No
Dry eyes	☐ Yes ☐ No		
Blur as though your glasses are dirty or like looking through mist or cellophane?	☐ Yes ☐ No	Reading newspaper, books or magazines	☐ Yes ☐ 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
Anemia	☐ Yes ☐ No	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	☐ Yes ☐ No
Sickle Cell	☐ Yes ☐ No	☐ Yes ☐ No
Clotting Disorders	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Thyroid	☐ Yes ☐ No	☐ Yes ☐ No
Auto Immune Disorders	☐ Yes ☐ No	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No	☐ Yes ☐ No
Systemic Connective Tissue Diseases	☐ Yes ☐ No	☐ Yes ☐ No
Dermatitis/Eczema/Psoriasis	☐ Yes ☐ No	☐ Yes ☐ No
Prostate Disease	☐ Yes ☐ No	☐ Yes ☐ No

Lung	Self	Family
Asthma	☐ Yes ☐ No	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	☐ Yes ☐ No

Vascular	Self	Family
Congestive Heart Failure	☐ Yes ☐ No	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	☐ Yes ☐ No

Other	Self	Family
Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	☐ Yes ☐ No
History of Keloid Scar Formation	☐ Yes ☐ No	☐ Yes ☐ No

Herpes	Self	Family
Cold Sores	☐ Yes ☐ No	☐ Yes ☐ No
Shingles	☐ Yes ☐ No	☐ Yes ☐ No
Other:	☐ Yes ☐ No	☐ Yes ☐ No

Are you currently taking long term corticosteroids? ☐ Yes ☐ No

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

OVER →

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 Accutane, 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:		
☐ Yes	☐ No	Fever or Fatigue?
☐ Yes	☐ No	Significant weight loss or gain?
☐ Yes	☐ No	Nose or throat problems?
☐ Yes	☐ No	Do you have trouble hearing?
☐ Yes	☐ No	Breathing Problems?
☐ Yes	☐ No	Heart Disease, angina, fainting spells or fluid retention?
☐ Yes	☐ No	Stomach or colon problems?
☐ Yes	☐ No	Bladder or kidney problems?
☐ Yes	☐ No	Skin problems?
☐ Yes	☐ No	Joint pain or stiffness?
☐ Yes	☐ No	HIV or hepatitis?
☐ Yes	☐ No	Seizures or TIA's?
☐ Yes	☐ No	Depression, anxiety, mood disorder or memory loss?
☐ Yes	☐ 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