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MEDICAL HISTORY FORM

Patient:____ Age: _______ DOB:________________

Primary Care Physician: ______________________________ Telephone: _________________

Referring Dr. ____ Telephone: ________________

Pharmacy: ____

Pharmacy Address: ____

Pharmacy Telephone: ____

Past Ocular History:

- ☐ Cataract
- ☐ Glaucoma
- ☐ Diabetic Eye Disease
- ☐ Dry Eye Syndrome
- ☐ Amblyopia (Lazy Eye)
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Iritis

Current EYE Medications:

Name	Eye	Frequency
__________________________	☐ **R** ☐ **L**	___________
__________________________	☐ **R** ☐ **L**	___________
__________________________	☐ **R** ☐ **L**	___________
__________________________	☐ **R** ☐ **L**	___________
__________________________	☐ **R** ☐ **L**	___________
__________________________	☐ **R** ☐ **L**	___________
__________________________	☐ **R** ☐ **L**	___________
__________________________	☐ **R** ☐ **L**	___________
__________________________	☐ **R** ☐ **L**	___________
__________________________	☐ **R** ☐ **L**	___________

Eye Surgery/Lasers/Injections:

☐ Eye Lid Surgery (Blepharoplasty or other eye lid surgery)

☐ Cataract surgery

☐ Glaucoma surgery (trab or tube)

☐ Glaucoma laser (laser iridotomy, SLT)

☐ Corneal surgery (LASIK/LASEK/PRK/RK/Corneal transplant/DSEAK)

☐ Retinal Laser (PRP) or retinal injections (Avastin)

☐ Retinal surgery (vitrectomy, retinal detachment repair, macular hole repair)

Any history of eye injury? If yes, please explain: ___________________________________

____

Date of last eye examination: ____

Do you wear glasses? ☐ **Yes** ☐ **No**

Do you wear contact lenses? ☐ **Yes** ☐ **No**

If yes, which brand and how long have your worn contact lenses?

____

Past Medical History:

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Bleeding problems
- ☐ Blood disorders
- ☐ Bronchitis/COPD
- ☐ Cancer ______________
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Dementia
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hearing Loss
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hepatitis A/B/C
- ☐ Herpes Simplex
- ☐ Herpes Zoster/Shingles
- ☐ HIV/AIDS
- ☐ Irregular Heart Beat
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Memory Loss
- ☐ Migraines
- ☐ MRSA
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polymyalgia
- ☐ Prostate Disease
- ☐ Psychiatric disorder
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Skin Cancer
- ☐ Syphilis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ OTHER list:

____

____

____

____

Past Surgical History or Hospitalizations: Please List

____

____

____

____

____

____

____

____

Current Medications (Not Eye):

Name	Dosage	Frequency

Do you take or have you ever taken the following Flomax (tamsulosin):

☐ **Yes** ☐ **No**

Drug Allergies: ☐ None Known

____

____

____

☐Latex allergy

☐IV contrast dye allergy

Family Ocular History:

☐Glaucoma

☐Cataract

☐ Macular degeneration

☐ Retinal Disease

☐Blindness

☐Cancer

☐ Other:___________________

Social History:

☐ Smoking ☐ current smoker

☐ former smoker

☐ never smoked

___packs/day ___years

☐ Alcohol:

☐ social/occasional ☐ often

________ drinks/day

☐ Recreational drug use _________

Are you pregnant? ☐ Yes ☐ No

Are you here for a work-related injury? ☐ Yes ☐ No

Have you notified your employer of your work related injury? ☐ Yes ☐ No

Do you currently have any problems in the following areas? If "YES", please provide information.

	YES	NO	Additional Comments
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watery			
Glare/light sensitivity			
Eye pain or soreness			
Tired eyes			
Droopy eye lid			
Blepharitis			
Crossed eye, lazy eye			
Sinus problems			
Vertigo			
Hearing loss			
Ringing in ears			

	YES	NO	Additional Comments
Headache			
Seizure			
Stroke			
Dizziness			
Elevated blood pressure			
Irregular heart beat			
Pacemaker			
Diabetes			
Thyroid abnormalities			
Wheezing			
Cough			
Shortness of breath			
Arthritis			
Joint pain			
Muscle pain			
Lupus or Sjogren's			
Allergies			
Hay fever			
History of STD's			
Urinary frequency			
History of kidney stones			
Diarrhea			
Constipation			
Stomach ulcers			
Bleeding disorder			
Anemia			

	YES	NO	Additional Comments
Rash/Sores (on skin)			
Hives/Eczema			
Insomnia			
Anxiety/Depression			
Weight loss/gain			
Fever			
COVID Risk: Fever, cough, sore throat, weakness, muscle pain, recent loss of taste or smell, vomiting, diarrhea, contact with anyone with COVID-19 or COVID like symptoms			
Defibrillator			
Flomax			
Blood thinners			

Print Patient Name: ____

Sign Patient Name: ____

Date: ______________________________