OFFICE PARK EYE CENTER
MEDICAL HISTORY FORM

Date: ______________________

Patient Name: ______________________________________ Date of Birth: ________________ Race: ____ Sex: M / F

Family Medical Doctor: ______________________________ When did you last see this doctor? _______________________

Do you see any specialists? (i.e. Cardiologist, Urologist, etc): ____

Medical History: Have you ever been treated for any of the following? **Please circle all that apply**

Diabetes (Type 1 / Type 2, Age at diagnosis ____, Insulin? Yes / No)
Cancer (Type: _____________, Chemo? Yes / No, Radiation? Yes / No)
High Blood Pressure
Heart Disease
Thyroid Disease
Asthma/COPD/Lung Disease
Stroke
High Cholesterol
Arthritis
Other: ______________________________________

Surgeries: Please list any surgeries and the approximate year

____

____

Medications: Please list names, dosages and how many times per day you take them

____

____

____

***Drug Allergies/Reactions**: ____

FAMILY History: *Has anyone in your immediate family (parents, siblings, children) been treated for any of the following?*

Glaucoma (who? ____________________)
Cataracts (who? ____________________)
Macular Degeneration (who? ____________________)
Eye Injury (who? ____________________)
Retinal Disease (who? ____________________)
Blindness (who? ____________________)
Lazy Eye(s) (who? ____________________)
Other ______________________________________
Diabetes (who? ____________________)
Cancer (who? ____________________)
Heart Disease (who? ____________________)
Hypertension (who? ____________________)
High Cholesterol (who? ____________________)
Kidney Disease (who? ____________________)
Stroke (who? ____________________)

Social History:

*Do you smoke? Yes / No (If so, How much? ____ ppd)
**Have you ever smoked? Yes / No
**If yes, how long ago did you quit? __________
*Do you drink alcohol? Yes / No How often? _______
*Do you live alone? Yes / No With family / friend / rest home?
*Do you drive? Yes / No

Review of Systems: Do you currently have any of the following problems? If yes, please describe.

Constitution (chronic fever, weight loss/gain, fatigue, etc)................................. YES...... NO ___________________________
Cardiovascular (chest pain, irregular heartbeat, etc)... YES...... NO ___________________________
Ear, Nose, Throat (hearing loss, sinus problems, etc).. YES...... NO ___________________________
Respiratory (short of breath, wheezing, coughing, etc) .... YES...... NO ___________________________
Gastrointestinal (heartburn, diarrhea, vomiting, etc) .... YES...... NO ___________________________
Urinary (pain/discomfort, blood in urine, etc) .... YES...... NO ___________________________
Musculoskeletal (joint pain, swollen joints, muscle aches, etc) .... YES...... NO ___________________________
Skin problems (rashes, excessive dryness) .... YES...... NO ___________________________
Neurologic (numbness, weakness, headaches, etc) .... YES...... NO ___________________________
Psychiatric (depression, anxiety, etc) .... YES...... NO ___________________________
Endocrine (diabetes, hypoglycemia, etc) .... YES...... NO ___________________________
Hematologic/Lymphatic (excess bleeding, anemia, etc) .... YES...... NO ___________________________
Allergic/Immunologic (HIV/AIDS, allergies, etc)... YES...... NO ___________________________