MEDICAL INFORMATION REVIEW

NAME: _______________________________ **DATE OF BIRTH:**_______________**DATE:**_____________

NAME OF YOUR PRIMARY CARE DOCTOR:____

LIST YOUR OCCUPATION:____

REVIEW OF SYSTEMS:

PLEASE CIRCLE ANY SYMPTOMS YOU CURRENTLY HAVE. ( )**NONE**

GENERAL - weight gain weight loss fatigue fever or chills

HEENT - decreased hearing tinnitus dry mouth

CARDIOVASCULAR - chest pain palpitations shortness of breath edema

PULMONARY - cough wheezing

DERMATOLOGICAL - rash itching

GASTROINTESTINAL - nausea constipation diarrhea jaundice

GENITOURINARY - incontinence urgency

ENDOCRINE - dialysis

NEUROLOGICAL - dizziness fainting tremor

PSYCHIATRIC - anxiety memory loss depressed mood

HEMATOLOGIC - bruising bleeds easily

MUSCULOSKELETAL - muscle or joint pain gout

PAST MEDICAL HISTORY:

PLEASE CIRCLE ANY MEDICAL HISTORY THAT APPLIES TO YOU. ( )**NONE**

GENERAL - pregnant hepatitis cancer HIV positive AIDS

HEENT - sinus disease allergies Bell's Palsy

CARDIOVASCULAR - high blood pressure high cholesterol stroke CAD MI (heart attack) angioplasty bypass surgery A. fib. stents

PULMONARY - asthma COPD emphysema sleep apnea

DERMATOLOGICAL - rosacea eczema skin cancer psoriasis

GASTROINTESTINAL - Chron's disease IBS diverticulitis kidney disease/failure

GENITOURINARY - BPH prostate cancer

ENDOCRINE - diabetes hyperthyroid hypothyroid dialysis

NEUROLOGICAL - MS Myasthenia Gravis CVA (stroke) TIA seizures Alzheimer's dementia

PSYCHIATRIC - depression anxiety bipolar schizophrenia

HEMATOLOGIC - anemia DVT sickle cell anemia

MUSCULOSKELETAL - arthritis (RA or OA) polymyalgia rheumatica Sjogrens lupus fibromyalgia

-OVER-

DO YOU HAVE ANY METAL IN YOUR BODY? **Yes/No**

PATIENT OCULAR HISTORY:
(PLEASE CIRCLE YES OR NO)

Macular Degeneration	Yes/No
Cataract	Yes/No
Diabetic Retinopathy	Yes/No
Dry Eye	Yes/No
Glaucoma	Yes/No
Retinal detachment	Yes/No
Macula hole	Yes/No
Amblyopia (lazy eye)	Yes/No
Eye Surgery	Yes/No
Eye Injury	Yes/No
Flashes or Floaters	Yes/No

FAMILY HISTORY:
DOES ANYONE IN YOUR FAMILY HAVE THE FOLLOWING?

Glaucoma	Yes/No	If yes who?______________
Diabetes	Yes/No	If yes who?______________
Macular Degeneration	Yes/No	If yes who?______________
Cataracts	Yes/No	If yes who?______________
Strabismus	Yes/No	If yes who?______________
Blindness	Yes/No	If yes who?______________

SOCIAL HISTORY (Please Circle)

Tobacco Use:	Current Smoker	Former Smoker	Never Smoked	
Alcohol Use:	Current Drinker	Social Drinker	Former Drinker	Never Drank

PAST SURGICAL HISTORY: (PLEASE PROVIDE DATE IF KNOWN)

___________________ ____________________ ____________________ ____________________

___________________ ____________________ ____________________ ____________________

ALLERGIES TO MEDICATIONS: **( )** NONE KNOWN

___________________ ____________________ ____________________ ____________________

LIST ANY EYE MEDICATIONS YOU ARE USING:

___________________ ____________________ ____________________ ____________________

LIST ANY DAILY MEDICATIONS WITH DOSAGE:

___________________ ____________________ _____________________ ____________________

___________________ ____________________ ______________________ ____________________

___________________ ____________________ ______________________ ____________________