

Medical Information Review

Name: _____ Date of Birth: _____ Date: _____

Name of Primary Care Doctor: _____

Past Medical History:

<u>Yes</u>	<u>No</u>	
___	___	High Blood Pressure
___	___	Heart Disease/Heart Attack
___	___	Breathing/Respiratory Problems
___	___	Thyroid Disease
___	___	Diabetes
___	___	Arthritis
___	___	High Cholesterol
___	___	Neurological Problems
___	___	Stroke(s)
___	___	Cancer

Past Ocular History:

<u>Yes</u>	<u>No</u>	
___	___	Eye Surgery
___	___	Injury
___	___	Lazy Eye or Patching
___	___	Flashes or floaters

Family Ocular History:

<u>Yes</u>	<u>No</u>	
___	___	Glaucoma
___	___	Cataracts
___	___	Blindness
___	___	Diabetes
___	___	High Blood Pressure

Review of Systems:

Do you currently have or recently have had any of the following symptoms:

<u>Yes</u>	<u>No</u>	
___	___	Fever
___	___	Weight Loss
___	___	Fatigue/Weakness
___	___	Ear, Nose or Throat Problems
___	___	Heart Disease Symptoms
___	___	Respiratory/Lung Problems
___	___	Gastrointestinal Problems
___	___	Skin Cancer/Disease
___	___	Arthritis or Lupus
___	___	Joint or Muscle Problems
___	___	Frequent Fainting or Dizziness
___	___	Migraines
___	___	Seizures
___	___	Depression/psychological illness
___	___	Anemia
___	___	Bleeding
___	___	Hepatitis
___	___	HIV Positive
___	___	Are you pregnant?

Past Surgical History:

_____	_____
_____	_____
_____	_____

Allergies to Medications: None

_____	_____
_____	_____

Social History:

<u>Yes</u>	<u>No</u>	
___	___	Do you smoke? ___ Pks/Day
___	___	Do you drink alcohol?

List your Occupation:

_____ or retired

List any Daily Medications you are using:

_____	_____
_____	_____
_____	_____
_____	_____

List any Eye Medications you are using:

_____	_____
_____	_____
_____	_____

Reviewed by:

Date: _____ Tech _____ MD _____

Date: _____ Tech _____ MD _____

Date: _____ Tech _____ MD _____