

PATIENT MEDICAL HISTORY RECORD

DATE (MM/DD/YY)	REFERRED BY	BIRTH DATE
PATIENT'S NAME		SEX AGE
ADDRESS		HOME PHONE
EMAIL	CELL PHONE	WORK PHONE
SOC SEC NO.		PRIMARY CARE PHYSICIAN
EMERGENCY CONTACT		PHONE

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)?
Yes No If YES, please explain: _____
2. Have YOU ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
Yes No If YES, please explain: _____
3. Have you ever had any surgery?
Yes No If YES, please list _____
4. Have you ever been hospitalized?
Yes No _____
5. What medicines do you take?
PLEASE LIST; _____
Do you take any eye medications: _____
Yes No If YES, please list: _____
6. Do you have any drug or food allergies?
Yes No If YES, please list: _____

Review of Systems

Do you currently have any of the following problems?

	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (e.g. pain or discomfort, blood in urine).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, excessive dryness).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g., depression, anxiety).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV, Hepatitis(specify), Tuberculosis, etc.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood Pressure, cancer, glaucoma, macular degeneration)?

Yes No If YES, please explain: _____

Do you smoke? If Yes, how much? Drink alcohol? If Yes, how much

If employed, how many hours per week do you work?

Do you have a living will? YES / NO

Signature

Date