

# 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**

	Yes	No	If YES, please explain:
Do you currently have any of the following problems?			
Chronic fever, unexpected weight loss/gain, fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore.....)	<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