



MEDICAL INFORMATION

NAME _____ AGE _____ DATE _____

DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____ CHART _____

(For Office Use)

PCP _____ REFERRED BY _____

I. PAST HISTORY:

1) **MEDICATION ALLERGIES (Including TYPE of Reaction):**

2) **MEDICAL CONDITIONS:**

3) **PAST SURGERIES (All Types) and HOSPITALIZATIONS:**

4) **CURRENT MEDICATIONS: (Including Over The Counter, Vitamins, and Herbal
Please include DOSAGES and REASON for taking)**

II. PERSONAL EYE HISTORY:

- | | | |
|--|--|---|
| <input type="checkbox"/> Eye injury/Trauma | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Crossed or Lazy Eye | <input type="checkbox"/> Retinal Problems | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tearing/Itching/Burning | |

III. FAMILY HISTORY OF:

- | | | |
|---|--|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Crossed Eyes/Lazy Eye | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blindness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Retinal Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other _____ |

IV. SOCIAL HISTORY:

- | | |
|--|---|
| <input type="checkbox"/> Recreational Drug Use | Do you live: <input type="checkbox"/> Alone |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> With Spouse |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Other |

Physician Signature

FOR OFFICE USE ONLY PLEASE DO NOT WRITE BELOW THIS LINE

PFSH + ROS UPDATE

Year Initials Year Initials Year Initials Year Initials

V. REVIEW OF SYSTEMS:

NORMAL	SYSTEM	COMMENTS
<input type="checkbox"/>	Constitutional	Fever Weight Loss/Gain Other _____
<input type="checkbox"/>	Ears/Nose/Throat	Pain Mass/Discharge Loss of Hearing/Smell Other _____
<input type="checkbox"/>	Cardiovascular	Chest Pain/Angina Congestive Heart Failure MI/Bypass/Angioplasty Arrhythmia/Blockages Hypertension - Stable: YES OR NO Last BP _____
<input type="checkbox"/>	Respiratory	Asthma Emphysema Cough Other _____ Use of Oxygen at Home ____ YES Sleep Apnea: CPAP YES or NO
<input type="checkbox"/>	Gastrointestinal	Digestive Problems Pain/ Ulcers Other _____
<input type="checkbox"/>	Genitourinary	Frequent Urination Burning Urination
<input type="checkbox"/>	Hematologic - Lymphatic	Anemia Blood Disorder Swollen Lymph Nodes Other _____ Hepatitis A ____ B ____ C ____ HIV + ____ YES
<input type="checkbox"/>	Musculoskeletal	Weakness Joint Pain/Arthritis Other _____
<input type="checkbox"/>	Skin - Integumentary	Masses-Tumors Lesions/Rashes Other _____
<input type="checkbox"/>	Neurologic	Weakness/Tingling/Numbness Stroke/Brain Injury Other _____
<input type="checkbox"/>	Psychiatric	Depression Other _____
<input type="checkbox"/>	Endocrine	Thyroid Graves Disease Diabetes: How Many Years? ____ Stable: YES or NO Last BS ____
<input type="checkbox"/>	Autoimmune	Lupus Rheumatoid Arthritis Cancer