Patient Medical History Record

Male Female

↑Your Name ↑Your Sex ↑Your Age

↑Referred By ↑Cardiologist

↑Primary Care Physician ↑Endocrinologist

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 eye, detached retina, and droopy eyelid)?
   Yes ❐ No ❐ If **YES**, please explain:________________________________
3. Have you ever had any surgery?
   Yes ❐ No ❐ If **YES**, please provide date and reason:________________________________
4. Have you ever been hospitalized?
   Yes ❐ No ❐ If **YES**, please provide date and reason:________________________________
5. Do you take any medication?
   Yes ❐ No ❐ If **YES**, please list:________________________________
6. Do you use any eye drops?
   Yes ❐ No ❐ If **YES**, please list:________________________________
7. Do you have any food or drug 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, unexplained weight loss/gain, fatigue	❐	❐	______________
Ear/nose/throat problems **(e.g., hearing loss, sinus problems, sore throat)**	❐	❐	______________
Heart problems **(e.g., chest pain, irregular heat beat, heart attack)**	❐	❐	______________
Respiratory problems **(e.g., shortness of breath, wheezing, coughing)**	❐	❐	______________
Gastrointestinal problems **(e.g., heartburn, belly pain, diarrhea, vomiting)**	❐	❐	______________
Urinary problems **(e.g., Pain or discomfort, blood in urine)**	❐	❐	______________
Skin problems **(e.g., excessive dryness)**	❐	❐	______________
Muskulosketelal problems **(e.g., muscle aches, joint, pain, swollen joints)**	❐	❐	______________
Neurological problems **(e.g., Numbness, weakness, headaches, paralysis)**	❐	❐	______________
Psychiatric problems **(e.g., depression, anxiety)**	❐	❐	______________

FAMILY & SOCIAL HISTORY

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

Yes ❐ No ❐ If **YES**, please explain:________________________________

Do you Smoke? Yes ❐ No ❐ If **YES**, how much? ________________________

↑Comments

↑Signature ↑Date