Patient Medical History

Name: ____ ______________
First Middle Last Nickname

What brings you in for examination, or what concerns do you have with your eyes? ______________________________

Eye history, including surgeries: ______________________________

Past medical history: ______________________________

Past surgical history: ______________________________

Family history of eye problems: Cataracts / Macular Degeneration / Blindness / Glaucoma / Diabetes / Other: ______________________________

Social history: Tobacco use (present/past) / Alcohol abuse / Drug addiction / Other: ______________________________

Do you have any new on going problems with the following review of systems:
(circle None if no problems)

In General: ______________________________ / None
Neurological: ______________________________ / None
Skin: ______________________________ / None
Ears: ______________________________ / None
Nose : ______________________________ / None
Respiratory: ______________________________ / None
Cardiovascualr: ______________________________ / None
Gastro-intestinal: ______________________________ / None
Genito-urinary: ______________________________ / None
Musculoskeletal: ______________________________ / None
Endorcrine:Immunological: ______________________________ / None
Psychiatric: ______________________________ / None

Eye medications / eyedrops: ______________________________
____
____

Other medications you take: ______________________________
____
____
____

Are you allergic to any medications, soaps, or topical iodine? yes / no

Please specify: ______________________________