EYES, P.A.

MEDICAL HISTORY FORM – NEW PATIENT

Date:

NAME:	Birthdate:

Sex: ❑ F ❑ M   Do you wear prescription glasses? ❑ Yes ❑ No   Do you wear contacts? ❑ Yes ❑ No

Parent/Guardian (if under 18)

Primary Care Physician (PCP):	PCP Office Location:	Date Last seen by PCP:

Primary Reason for Today's Visit:

Date Last Eye Exam: By Dr.:

EYE CONDITIONS (check all that apply)		
❑ Pain ❑ Redness	❑ Double ❑ Blurred Vision	❑ Glare ❑ Light Sensitivity ❑ Halos
❑ Loss of vision	❑ Dryness ❑ Gritty Feeling ❑Tearing	❑ Flashes of Light or ❑ Floaters
❑ Itching ❑ Burning ❑ Discharge	❑ Irritation of Eyelashes or Eyelids	❑ NONE
❑ Explain		

PERSONAL & FAMILY MEDICAL HISTORY

Do you or anyone in your immediate family have any of the following heath conditions? Please provide details/explanation.

	SELF	FAMILY MEMBER*	* Relationship to you
Amblyopia (Lazy Eye)	❑	❑	___
Blindness	❑	❑	___
Cataracts	❑	❑	___
Glaucoma	❑	❑	___
Retinal Disorder	❑	❑	___
Strabismus	❑	❑	___
Macular Degeneration	❑	❑	___
Arthritis	❑	❑	___
Cancer (Type)	❑	❑	___
Diabetes ❑Type I ❑Type II	❑	❑	___
High Blood Pressure	❑	❑	___
Seizures	❑	❑	___
Heart problems	❑	❑	___

Other medical conditions (please list): ___

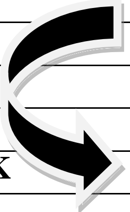
___

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes Please List:

Please list all medications that you are currently taking. Include **eye drops,** medical marijuana, non-prescription medication, vitamins & supplements:

Name of drug & Strength ❑ NONE	**Name of drug & Strength**



CONTINUED ON BACK

SYSTEMS REVIEW

Are you currently experiencing any of the following health conditions? Check all that apply

GENERAL/CONSTITUTION
❑ Recent weight gain/Loss
❑ Fatigue
❑ Weakness
❑ Insomnia
❑ Explain______________________
❑ NONE

CARDIOVASCULAR *(Heart/Blood)*
❑ Heart Disease
❑ Pacemaker
❑ Stent
❑ Hypertension (High Blood Pressure)
❑ High Cholesterol
❑ History of Stroke
❑ Explain________________________
❑ NONE

EARS/NOSE/THROAT
❑ Ringing in ears
❑ Loss of hearing
❑ Frequent sore throats
❑ Sinus Problems
❑ Explain______________________
❑ NONE

RESPIRATORY *(Lungs/Breathing)*
❑ Asthma
❑ COPD
❑ Explain________________________
❑ NONE

GASTROINTESTINAL
(Stomach/Intestines)
❑ Heartburn
❑ Nausea
❑ GERD
❑ Explain________________________
❑ NONE

MUSCULOSKELETAL
(Muscle/Joints/Bones)
❑ Arthritis ❑ Rheumatoid ❑ Osteo
❑ Numbness
❑ Joint pain
❑ Muscle weakness
❑ Joint swelling
Where? ________________________
❑ NONE

INTEGUMENT *(Skin)*
❑ Redness ❑ Rash
❑ Rosacea
❑ Eczema
❑ Explain________________________
❑ NONE

PSYCHIATRIC
❑ Anxiety
❑ Depression
❑ Bipolar
❑ Dementia
❑ PTSD
❑ Explain________________________
❑ NONE

NERVOUS SYSTEM
❑ Headaches ❑ Migraines
❑ Dizziness ❑ Vertigo
❑ Fainting or loss of consciousness
❑ Numbness or tingling
❑ Memory loss
❑ Epilepsy
❑ Seizures
❑ Explain________________________
❑ NONE

ENDOCRINE
❑ Hormone Imbalance
❑ Diabetes; Type ❑ I ❑ II
❑ Thyroid; Hypo ❑ Hyper ❑
❑ Explain ________________________
❑ NONE

ALLERGIC/IMMUNOLOGIC
❑ Seasonal Allergies
❑ HIV
❑ Lupus
❑ Explain ________________________
❑ NONE

HEMATOLOGICAL/LYMPHATIC
❑ Raynaud's Syndrome
❑ Leukemia
❑ Hemophilia
❑ Anemia
❑ Clots
❑ Explain________________________
❑ NONE

OTHER MEDICAL CONDITIONS: *please list*

SURGICAL HISTORY

Please list all major surgeries including any Eye Procedures (Cataract, Lasik, etc):

Date/Year	Procedure	Date/Year	Procedure

PERSONAL SOCIAL HISTORY

Height: ________ ft _________ in Current Weight: __________ lbs

If female: Are you Pregnant? ❑ No ❑ Yes (Due Date ____________) Or Nursing? ❑ No ❑ Yes

Daily Computer Use: *including Tablets, Kindles, Phones & Other Electronic Devices* ❑ None ❑ #________ Hours per Day

Tobacco Product Use:
❑ Yes ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Chewing Tobacco ❑ No ❑Never Smoker ❑ Former Smoker since _________
❑ Daily ❑ Occasionally

Alcohol Use:
❑ Yes (❑ Beer/wine ❑ Hard liquor) ❑ Current non-drinker
❑ Daily ❑ Socially

Recreational Drug Use:
❑ Yes (please list type & frequency): ❑ No