

MEDICAL INFORMATION

Date _____

Referred by _____

Name _____

Family Physician _____

I. Past History:

1) Are you allergic to any medications? If yes, please list:

2) Past and Present Medical History:

Are you diabetic?: Yes No Borderline

At what age were you diagnosed?: _____

Controlled with: (circle one) Insulin Pills Diet

Is your diabetes uncontrolled?: Yes No

3) **Are you pregnant or think you might be? Yes No**

4) All Past Surgical History:

Have you had refractive surgery?

Circle one: LASIK LASEK PRK RK

When?: _____ Which eye: R L

5) Current Medications (Name & Associated illness):

II. Social History:

Do you smoke? _____

How much/wk? _____

Do you drink alcohol? _____

How much/wk? _____

Do you take illicit drugs? _____

Do you live: alone with spouse nursing home/assisted living family

III. Family History (list whom, i.e., mother, father grandparents, brother, sister, etc):

Cataracts _____

Diabetes _____

Glaucoma _____

High Blood Pressure _____

Retinal Detachments _____

Heart Disease _____

Eye Disorders _____

Other _____

CONTINUED ON REVERSE

FOR OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

PFSH + ROS Updated:

Date Initials

NOTE: Please place an "X" in the box if you CURRENTLY have any of the following symptoms. If not, please check the box marked "NORMAL."

III. Review of Systems

- | | | |
|-------------------------------|---|---|
| 1. GENERAL HEALTH | <input type="checkbox"/> Normal | <input type="checkbox"/> Fever |
| | | <input type="checkbox"/> Unexplained weight loss/ gain |
| | | <input type="checkbox"/> Other _____ |
| 2. EYES | <input type="checkbox"/> Normal- Routine exam | <input type="checkbox"/> Blurred vision |
| | | <input type="checkbox"/> Double vision |
| | | <input type="checkbox"/> Pain |
| | | <input type="checkbox"/> Discharge |
| | | <input type="checkbox"/> Other symptoms _____ |
| 3. EARS, NOSE, MOUTH, THROAT | <input type="checkbox"/> Normal | <input type="checkbox"/> Pain/Discharge |
| | | <input type="checkbox"/> Mass |
| | | <input type="checkbox"/> Hearing Loss |
| | | <input type="checkbox"/> Smell problems |
| | | <input type="checkbox"/> Other _____ |
| 4. CARDIOVASCULAR | <input type="checkbox"/> Normal | <input type="checkbox"/> Chest pain |
| | | <input type="checkbox"/> Shortness of breath |
| | | <input type="checkbox"/> Irreg. heart beat |
| | | <input type="checkbox"/> Other _____ |
| 5. RESPIRATORY | <input type="checkbox"/> Normal | <input type="checkbox"/> Difficulty breathing |
| | | <input type="checkbox"/> Cough |
| | | <input type="checkbox"/> Asthma |
| | | <input type="checkbox"/> Other _____ |
| 6. GASTROINTESTINAL | <input type="checkbox"/> Normal | <input type="checkbox"/> Diarrhea |
| | | <input type="checkbox"/> Constipation |
| | | <input type="checkbox"/> Stomach pain |
| | | <input type="checkbox"/> Ulcers |
| | | <input type="checkbox"/> Other _____ |
| 7. HEMATOLOGIC/ LYMPHATIC | <input type="checkbox"/> Normal | <input type="checkbox"/> Anemia |
| | | <input type="checkbox"/> Difficulty clotting, i.e. "free bleeder" |
| | | <input type="checkbox"/> Swollen lymph nodes |
| | | <input type="checkbox"/> Other (i.e. blood disease) _____ |
| 8. BONES, JOINTS, EXTREMITIES | <input type="checkbox"/> Normal | <input type="checkbox"/> Joint pain |
| | | <input type="checkbox"/> Arthritis |
| | | <input type="checkbox"/> Decreased range of motion |
| | | <input type="checkbox"/> Other _____ |
| 9. SKIN/ BREAST | <input type="checkbox"/> Normal | <input type="checkbox"/> Masses |
| | | <input type="checkbox"/> Tumors |
| | | <input type="checkbox"/> Pigmented skin lesions |
| | | <input type="checkbox"/> Rash |
| | | <input type="checkbox"/> Other _____ |
| 10. NEUROLOGIC | <input type="checkbox"/> Normal | <input type="checkbox"/> Weakness |
| | | <input type="checkbox"/> Tingling Numbness |
| | | <input type="checkbox"/> Other _____ |