MEDICAL/EYE HISTORY UPDATE

Patient Name _____ Date _____

Please answer the following questions regarding updates to your medical and eye history.

Have you had any new eye surgery/injury or condition since your last exam?

❒ No ❒ Yes, please explain _____

_____

What is your chief complaint about your eyes? _____

_____

_____

Please list all **eye** medications you are currently using- list names and how often

_____

_____

Please list all **medical conditions** you are being treated for

_____

_____

_____

Have you had any surgeries, injuries or hospitalizations since your last visit?

❒ No ❒ Yes. Please List _____

Please list all medications (including vitamins) that you are currently using

_____

_____

_____

Please list any drug or food allergies that you have

_____

Do you smoke?	❒ No	❒ Yes. How much?	_____
Have you ever smoked?	❒ No	❒ Yes	
Do you drink alcohol?	❒ No	❒ Yes. How often?	_____
Do you use street drugs?	❒ No	❒ Yes	

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MEDICAL EYE HISTORY UPDATE

Do you currently have any of the following problems?	No	Yes	If Yes, please explain
Chronic Fever, unexpected weight loss/gain, fatigue	❒	❒	_____
Ear/Nose/Throat - hearing loss, sinus, sore throat, etc.	❒	❒	_____
Heart - chest pain, HTN, cholesterol, irregular heartbeat, etc.	❒	❒	_____
Respiratory - asthma, COPD, shortness of breath, etc.	❒	❒	_____
Gastrointestinal - GERD, heartburn, diarrhea, vomiting, etc.	❒	❒	_____
Urinary - pain, blood in urine, ulcer, discomfort, etc.	❒	❒	_____
Skin - rashes, rosacea, change in hair/nails, dryness, etc.	❒	❒	_____
Musculoskeletal - gout, arthritis, joint pain/swelling, etc.	❒	❒	_____
Neurological - numbness,weakness,paralysis, etc.	❒	❒	_____
Hematologic – blood diseases, etc.	❒	❒	_____
Psychiatric – depression, anxiety, etc.	❒	❒	_____
Immunologic – disorders, food/seasonal allergies, etc.	❒	❒	_____
Endocrine – diabetes, thyroid, hypoglycemia, etc.	❒	❒	_____
AIDS/HIV, MRSA, Hepatitis	❒	❒	_____

Has anyone in your immediate family been diagnosed with any eye diseases, diabetes, cardiovascular, high blood pressure or carotid artery disease since your last visit?

❒ No ❒ Yes, please explain _____

Signature _____Date_____

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