

PATIENT MEDICAL HISTORY RECORD

Date	Referred by self/Gp/Optician	Date of Birth
Full name		Sex Age
Address		Phone (H) (W) (M)
Optician	Lens prescription	Right / axis Left / axis
Insured no/yes Company	Policy No.	General practitioner

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 or "lazy" eye, retinal detachment)?
 Yes No If YES, please explain: _____
3. Have you ever had any surgery?
 Yes No If YES, please list _____
4. Have you ever been hospitalized?
 Yes No _____
5. Do you take any medications?
 Yes No If YES, please list: _____
 Do you take any eye medications: _____
 Yes No If YES, please list: _____
6. Do you have any drug or food 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, unexpected weight loss/gain, fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (e.g. pain or discomfort, blood in urine).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, excessive dryness).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g., depression, anxiety).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV, Hepatitis(specify), Tuberculosis, etc	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood Pressure, cancer, glaucoma, macular degeneration)?
 Yes No If YES, please explain: _____

Do you smoke? If Yes, how much? Drink alcohol? If Yes, how much

Signature _____

Date _____