

# Patient Medical History

**Patient please enter information here:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ Insurance: \_\_\_\_\_  
Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

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Referring Dr.: \_\_\_\_\_ Family MD (PCP): \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Does insurance require a referral?: **Y / N**

**Have you ever been treated for the following?**

- Y / N Eye inflammation (iritis/uveitis)
  - Y / N Cataract
  - Y / N Glaucoma
  - Y / N Eye trauma/injury
  - Y / N Cornea problem
  - Y / N Retinal tear/detachment
  - Y / N Macular degeneration
  - Y / N Diabetic eye disease
  - Y / N Perfect vision in both eyes in youth
  - Y / N Eye muscle problems (e.g. crossed eyes)
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- Y / N Diabetes \_\_\_\_\_ years
- Y / N High blood pressure \_\_\_\_\_ years
- Y / N Heart attack / heart disease
- Y / N Kidney disease / kidney stone
- Y / N Liver disease / hepatitis A, B, C
- Y / N Lung disease
- Y / N Neurologic: stroke
- Y / N Cancer — type: \_\_\_\_\_
- Y / N AIDS / HIV
- Y / N Abnormal bleeding tendency
- Y / N Arthritis
- Y / N Gastrointestinal problems
- Y / N Are you pregnant now or is there a possibility you may be?
- Y / N Born prematurely

General surgery? (Type[s] and date[s]): \_\_\_\_\_

List all current medications, strengths and dosage: \_\_\_\_\_

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Allergies and reactions: \_\_\_\_\_

Family history: Glaucoma **Y / N** Macular degeneration **Y / N** Retinal detachment **Y / N** Which relative?: \_\_\_\_\_

Occupation: \_\_\_\_\_ Retired: **Y / N** Alcohol drinker: **Y / N** ( \_\_\_\_\_ drinks per day).

Marital status: S M D W Present smoker: **Y / N** ( \_\_\_\_\_ packs per day).

Number of children: \_\_\_\_\_ Past smoker: **Y / N** ( \_\_\_\_\_ packs per day for \_\_\_\_\_ years).

Other: \_\_\_\_\_

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**ROS & HPI Performed by Dr.:** \_\_\_\_\_ **and dictated to:** \_\_\_\_\_