MIDWEST EYE INSTITUTE MEDICAL HISTORY

Name: _____ **Date:** _____

Primary Care Physician: _____ Referring Physician: _____

Reason for Referral: _____

MEDICAL HISTORY

☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease ☐ Diabetes ☐ Thyroid Disease ☐ History of Cancer
☐ Other (please explain): _____

Have you had a pneumonia shot within the past 5 years? ☐ Yes ☐ No

Have you had a current flu vaccine? ☐ Yes ☐ No

SURGICAL HISTORY

Please list all surgeries, including prior eye surgeries, and the date of each

_____

_____

_____

SOCIAL HISTORY

(Please Check the Box)

Marital Status: ☐Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Smoking: ☐ Smoker ☐ Ex- Smoker (Quit Date: _____) ☐ Never Smoked

Alcohol: ☐ None ☐Occasional or Social ☐1-2 Drinks/Day ☐3-4+ Drinks/Day

Occupation: _____

Living Condition: ☐Alone or With Spouse ☐ Nursing Home ☐ Family ☐ Caretaker ☐ Other_____

Use of Illegal Drugs: ☐ Yes ☐ No *If yes, what and how long?* _____

Have you ever had sexual contact with a person who was exposed to or is infected with a sexually transmitted disease? ☐ Yes ☐ No *If yes, please specify:* _____

MEDICATIONS

List all medications, both prescribe and over the counter, with the dosage and how often the medication is used **(including vitamins, supplements, herbs, and eye drops). You may also provide us with a copy of your own list of medications.**

NAME	FOR WHAT CONDITION	DOSAGE	HOW OFTEN?

CONTINUE ON REVERSE

Name: _____ **Date:** _____

ALLERGIES

Please check below for the type(s) of allergy and explain the type of reaction you experienced:

☐ Medication: _____

☐ Anesthesia: _____ ☐ Latex: _____ ☐Dye: _____

☐ Other, please explain: _____

FAMILY HISTORY

Please check below any hereditary condition that an **immediate family member** has been diagnosed with. Also indicate what family member(s) it applies to.

☐ Macular Degeneration: _____

☐ Glaucoma: _____

☐ Retinal Detachment: _____

☐ Diabetes: _____

☐ Cancer: _____

☐ Retinitis Pigmentosa: _____

☐ Other, please explain: _____

REVIEW OF SYSTEMS

Please check if you are currently experiencing or has experienced these symptoms/conditions.

Allergy and Immunology:
☐ Seasonal
☐ Autoimmune Disease
☐ Other: _____

Ocular Symptoms and Diseases:
☐Loss of Vision ☐Distorted Vision ☐Double Vision
☐Dryness ☐Itching or Burning Sensation ☐Eye Pain
☐Eye Injuries ☐Corneal Disease ☐Glaucoma
☐Lazy or Crossed Eyes ☐Macular Degeneration
☐Other: _____

Cardiovascular:
☐Chest Pain ☐Swelling of Feet
☐Shortness of Breath ☐Irregular Heartbeat
☐Other: _____

Constitutional:
☐ Fever ☐ Weight Loss ☐Fatigue ☐Loss of Appetite
☐ Other: _____

Endocrine:
☐Elevated Blood Sugar ☐Low Blood Sugar ☐Sweating
☐Other: _____

Gastrointestinal:
☐Abdominal Pain ☐Diarrhea ☐Ulcers
☐Other: _____

Musculoskeletal:
☐Muscle Aches ☐Joint Pain ☐Unable to Lay Flat
☐Other: _____

Genitourinary:
☐Kidney Stones ☐Dialysis
☐Bladder or Prostate Problem
☐Other: _____

Hematology & Oncology:
☐Prolonged Bleeding ☐Cancer
☐Other: _____

Head, Ears, Nose, and Throat:
☐Hearing Loss ☐Dry Mouth
☐Other: _____

Respiratory:
☐Difficulty Breathing ☐Wheezing ☐Cough

OB/GYN:
☐Breast Tenderness ☐Abnormal Menstruation
☐Other: _____

Integumentary:
☐Change in Mole(s) ☐Rash or Bruising
☐Other: _____

Neurological:
☐Headaches ☐Dizziness ☐Paralysis ☐Tremors
☐Other: _____

Psychiatric:
☐Anxiety ☐Depression
☐Other: _____

OTHER, please explain: _____

M.D. / Tech: _____ Date Reviewed: _____