MIDWEST EYE INSTITUTE MEDICAL HISTORY

Name____ Birthdate___________ Date______________

Name of physician referring you ____

Why did the physician refer you? ____

C.C. and P.I. (For Physician use only)

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If YES, provide information.

	YES	NO	**EXPLANATION OF PROBLEM** (Date of Onset)
Skin	☐	☐	________________
Rash, nodules, etc.	☐	☐	________________
Eyes	☐	☐	________________
Loss of vision	☐	☐	________________
Blurred vision	☐	☐	________________
Distorted vision	☐	☐	________________
Loss of side vision	☐	☐	________________
Double vision	☐	☐	________________
Dryness	☐	☐	________________
Mucous discharge	☐	☐	________________
Redness	☐	☐	________________
Itching	☐	☐	________________
Burning	☐	☐	________________
Excess tearing / watering	☐	☐	________________
Eye pain	☐	☐	________________
Chronic infection of eye or lid	☐	☐	________________
Lazy or crossed eyes	☐	☐	________________
Halos around lights	☐	☐	________________
Eye injuries	☐	☐	________________
Droopy eye lids	☐	☐	________________
Ears, nose, mouth, throat	☐	☐	________________
Sinus, congestion, runny nose	☐	☐	________________
Chronic cough, recent cold	☐	☐	________________

Name ____________________

	YES	NO	EXPLANATION OF PROBLEM (Date of Onset)
Respiratory (Lungs / breathing)	☐	☐	
Asthma, emphysema, coughing	☐	☐	
blood, tuberculosis, any lung disease	☐	☐	
Cardiovascular (Heart / Blood vessels)	☐	☐	
Chest pain, increased blood pressure	☐	☐	
heart attack, irregular heart beat, heart disease	☐	☐	
Gastrointestinal (Stomach / Intestines)	☐	☐	
Ulcers, blood in stools	☐	☐	
Genitourinary	☐	☐	
Genitals, kidney, bladder, prostate, stones	☐	☐	
OBGYN	☐	☐	
Cancer, lumps in breast, abnormal	☐	☐	
menstrual periods	☐	☐	
Bones, joints, muscles	☐	☐	
Muscle or joint pain	☐	☐	
Neurologic system	☐	☐	
Convulsions, stroke, paralysis,	☐	☐	
headaches, migraines	☐	☐	
Lymphatics (Lymph nodes, swelling)	☐	☐	
Blood	☐	☐	
Anemia, clots, excess bleeding, etc.	☐	☐	
Allergic / immunologic	☐	☐	
Hay fever symptoms, other allergies	☐	☐	
Psychiatric	☐	☐	
Diabetes	☐	☐	
Thyroid	☐	☐	

Please list any other conditions for which you have been under medical care ____________________

____

PAST HISTORY

List all surgeries, including eye surgeries, and date of each.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________

Any problems with anesthetics (local or general)? ☐ **YES** ☐ **NO**

If YES, please describe ____________________

Name ____

List all medications, vitamins, supplements **(Use Separate Sheet As Necessary)**

List all prescribed medications, how often medications are used, and dosage

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________

List all vitamins

1. ______________________
2. ______________________

List all supplements

1. ______________________
2. ______________________

List all herbs

1. ______________________
2. ______________________

Are you allergic to any medications? ☐ **YES** ☐ **NO**

If YES, list medications ______________________

Are you allergic to latex? ☐ **YES** ☐ **NO**

FAMILY HISTORY Do any family members have the following?

DISEASE	YES	NO	EXPLANATION OF PROBLEM / WHAT FAMILY MEMBER? *Example: Mother, Father, Sister, Brother*
Skin	☐	☐	
Corneal disease	☐	☐	
Glaucoma	☐	☐	
Lazy or crossed eyes	☐	☐	
Macular degeneration	☐	☐	
Retinal detachment	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart attack	☐	☐	
High blood pressure	☐	☐	
Kidney disease	☐	☐	
Stroke	☐	☐	
Thyroid disease	☐	☐	
Tuberculosis	☐	☐	
Any inherited disease	☐	☐	
Other	☐	☐	

Name ____

SOCIAL HISTORY

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Current Occupation____

Do you drive?	YES ☐	NO ☐
Do you have visual difficulty when driving?	YES ☐	NO ☐
Do you have a problem with night vision?	YES ☐	NO ☐
Do you currently wear glasses or contact lenses?	YES ☐	NO ☐
If YES, how long have you had them?	______________________	
Do you use street drugs?	YES ☐	NO ☐
If YES, please indicate what	______________________	
Do you drink alcohol?	YES ☐	NO ☐
If YES, how much per day	______________________	
Do you smoke?	YES ☐	NO ☐ Quit Date ____________
If YES, how many packs a day?	______________________	

Have you ever had intimate contact with a person who may have been exposed to or is infected with a sexually transmitted disease? YES ☐ NO ☐

Is there any other information that you want to make certain that the physician knows? ____________________
____

RECAP - Eye Medication: Rx, Eye, Orders

______________ ______ Eye Orders ______________________
______________ ______ Eye Orders ______________________
______________ ______ Eye Orders ______________________
______________ ______ Eye Orders ______________________

Misc: ____
____
____

Office Use Only Do Not Write Below Double Line

RECAP - Past Eye History / Surgery (Date, diagnoses, therapy, surgery, M,D.)

All (4) pages of history reviewed. Additions made as noted.

______________________________M.D.

______________________________ Tech