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 ☐ Sweat
☐ Other:

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

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

Genitourinary:
☐ Kidney Stones ☐ Dialysis
☐ Bladder/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: