

Name: \_\_\_\_\_ Date: / /

**Medical and Family History:** Please check (☑) the following if they apply to yourself(S) or to your family members(F).

S	F		S	F		S	F	
		Anemia			Emphysema			Kidney Disease
		Arthritis			Gout			Seizures
		Asthma			Heart Attack			Stroke
		Cancer			Hepatitis			Thyroid Disease
		Diabetes			High Blood Pressure			Vascular Disease

**Other Medical Problems:**

**Previous Surgery (Not Eye surgery):** Please give approximate dates  no prior surgery

**Previous Injuries:** Please give approximate dates

**Previous Treatments or Hospitalizations:** Please give approximate dates

- Sexually Transmitted Disease     
  Lyme Disease     
  Cytomegalovirus  
 Meningitis     
  AIDS     
  Dialysis

**Medications (Not Eye medications, include nonprescription drugs):**  no medications

**Allergies and Drug Reactions:**  no allergies

**Social History:** Circle your answer

Do you drink alcohol?    no    yes (if yes, explain) \_\_\_\_\_

Do you smoke now?    no    yes (if yes, explain) \_\_\_\_\_

Have you smoked in past? no    yes (if yes, how long \_\_\_\_\_ yrs; quit smoking \_\_\_\_\_ yrs. ago)

Do you use street drugs? no    yes (if yes, explain) \_\_\_\_\_

Do you live alone?    no    yes

Are you driving?    no    yes

Name: \_\_\_\_\_

Date: / /

**REVIEW OF SYSTEMS:** If you are currently having any problems in the following areas, **please circle and explain.**

**SKIN:** itching, rash, infection, ulcer, tumors(growths), other  none

**LYMPH NODES:** swelling, tenderness, other  none

**BONES, JOINTS, MUSCLES:** muscle pain/cramps, joint pain/swelling, other  none

**ENDOCRINE:** fatigue, confusion, fainting, nervousness, hot/cold intolerance, hair loss, other  none

**ALLERGY/IMMUNOLOGY:** recurrent infections, hayfever, hives, food allergy, drug sensitivity, other  none

**HEAD:** headaches, dizziness, vertigo, other  none

**EARS:** hearing loss, ringing, infections, other  none

**NOSE:** bleeding, loss of smell, congestion, sinus problems, other  none

**THROAT:** dry mouth, loss of taste, difficulty swallowing, hoarseness, other  none

**NECK:** pain, swelling, stiffness, other  none

**BREASTS:** tenderness, swelling, lumps, discharge, other  none

**BLOOD:** fever/chills, bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other  none

**RESPIRATORY:** wheezing, cough(productive/blood), difficulty breathing, asthma, other  none

**CARDIOVASCULAR**(heart/blood vessels): chest pain, swelling of extremities, shortness of breath, exercise intolerance, other  none

**GASTROINTESTINAL**(stomach/intestines): nausea, vomiting, change in bowel habits, constipation, diarrhea, pain/cramps, bleeding, other  none

**GENITOURINARY**(genitals/kidney/bladder): frequency, burning, hesitancy, pain or bleeding on urination, infections, incontinence, impotence, other  none

**NERVOUS SYSTEM:** weakness in arms or legs, numbness or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other  none

**PSYCHIATRIC:** disorientation, mood swings, anxiety, depression, hallucinations, other  none

This form completed by: Patient      Family      Staff

History reviewed by \_\_\_\_\_ M.D.      Date \_\_\_\_\_