HEART OF AMERICA EYE CARE

Medical History

Name_____ Birth date_____ Today's date_____

Why are you here today?_____

Circle "S" if <u>you</u> have the condition or "F" if a family member has the condition:

		EYE			MUSCULOSKELETAL	S	F	Ulcerative colitis
S	F	Cataracts	S	F	Arthritis	S	F	Abdominal pain
S	F	Glaucoma	S	F	Joint pain			URINARY
S	F	Dry eyes	S	F	Muscle aches	S	F	Enlarged prostate
S	F	Macular degeneration	S	F	Low back pain	S	F	Blood in urine
S	F	Retinal tear/detachment				S	F	Excessive urination
S	F	Fuch's Dystrophy			IMMUNOLOGIC	S	F	Pain w/ urination
S	F	Lazy eye/strabismus	S	F	Rheumatoid arthritis			
S	F	Prior LASIK/PRK/RK	S	F	Sjogren's syndrome			NEUROLOGIC
			S	F	Lupus	S	F	Depression
		HEART	S	F	Sarcoidosis	S	F	Anxiety
S	F	High blood pressure	S	F	Juvenile rheumatoid arthritis	S	F	Headaches
S	F	Coronary artery disease	S	F	Ankylosing spondylitis	S	F	Migraines
S	F	Congestive heart failure	S	F	HLA-B27	S	F	Numbness
S	F	Irregular heart beat	S	F	Myasthenia gravis	S	F	Weakness
S	F	Chest pain				S	F	Alzheimer's disease
S	F	Vascular problems			EAR, NOSE, THROAT	S	F	Memory loss
			S	F	Seasonal allergies			
		RESPIRATORY	S	F	Hearing loss			GENERAL HEALTH
S	F	Asthma	S	F	Sinus problems	S	F	Fatigue
S	F	COPD/emphysema	S	F	Sore throat	S	F	Unexpected weight loss/gain
S	F	Sleep apnea				S	F	Hepatitis
S	F	Shortness of breath			SKIN DISORDERS	S	F	HIV/AIDS
S	F	Wheezing	S	F	Rosacea			
S	F	Coughing	S	F	Eczema			CANCER
			S	F	Excessive dry skin	S	F	Melanoma
		ENDOCRINE				S	F	Skin cancer
S	F	High cholesterol			GASTROINTESTINAL	S	F	_____
S	F	Type I diabetes since _____	S	F	Acid reflux	S	F	_____
S	F	Type 2 diabetes since _____	S	F	Ulcers			
S	F	Thyroid disorder	S	F	Crohn's disease			
S	F	Grave's disease						

Other conditions not listed above_____

Eye medications/drops_____

Other medications (or attach list)_____

_____

Allergies (medications, food, etc)_____

Eye surgeries_____

Major surgeries (with date); minor surgeries in last 5 years_____

_____

Do you smoke? Never Current Former _____ packs/day for _____ years (quit _____ yrs ago)

Do you drink alcohol? No Rare Yes _____ drinks per *(circle):* day week month