BOSTON EYE CARE CONSULTANTS

Robert A. Lytle, MD
Eye Physician and Surgeon

Patient Health History

Primary Care Physician _____

Pharmacy and location _____

Do you smoke? YES: How much per day? _____ NO
Have you ever smoked? YES: When did you quit?_____ NO
Do you drink alcohol? YES: How much per day? _____ NO
Do you use recreational drugs? YES NO Previous user
Do you drive during the day? YES NO Do you have difficulty? YES NO
Do you drive at night? YES NO Do you have difficulty? YES NO
Have you had eye surgery or eye laser surgery? YES NO
Please list procedure, including date and eye _____

_____

_____

_____

Please list any other surgical procedures and year_____

_____

_____

_____

Have you ever had complications under anesthesia? YES NO

Have you ever had:
Cancer YES Type_____Location_____Date_____
NO

How would you rate your health?
POOR FAIR GOOD EXCELLENT

Allergies_____

_____

_____

_____

Past Medical History

Have you ever been/are you being treated for:

Diabetes YES NO

Heart Disease YES NO

High Cholesterol YES NO

Lazy Eye YES NO

Prostrate Problems YES NO

Respiratory Disease YES NO

Glaucoma YES NO

Difficulty Hearing YES NO

Have you ever had:

Shingles/Rosacea near your eyes or face YES NO

Eye ulcers or long-term eye infections YES NO

Do you/have you ever worn contacts YES NO

Have you had injections for retinal problems YES NO

Family History (blood relatives)

Glaucoma? YES NO Details _____

Cataracts? YES NO Details _____

Muscle Imbalance? YES NO Details_____

Retinal Disease? YES NO Details _____

Macular Disease? YES NO Details _____

Color Blind? YES NO Details _____

Vision Loss? YES NO Details _____

Review of Systems

This information is needed for qualilty of care, as many systemic diseases and medical problems may affect your vision ad eye health. We also need this information to fulfill requirements many insurance companies have set forth for documentation of level of care and quality measures.

General
___ Fever
___ Weight loss
___ Weight gain

Integumentary
___ Changing moles
___ Rash
___ Itching

Ears/Nose/Throat
___ Hearing loss
___ Dry mouth
___ Sinus problems

Respiratory
___ Wheezing
___ Congestion
___ Cough

Cardiovascular
___ Irregular/rapid heartbeat
___ High blood pressure
___ Swelling of feet/ankles

Gastrointestinal
___ Diarrhea
___ Constipation
___ Nausea

Musculoskeletal
___ Joint pain
___ Back pain/stiffness
___ Arthritis

Neurological
___ Dementia
___ Headaches
___ Stroke
___ Seizures

Endocrine
___ Diabetes
___ Thyroid abnormalities
___ Fatigue

Gynecological *(women only)*
___ Pregnant or planning

Hemato/Lymphatic
___ Swollen lymph nodes
___ Bleed easily
___ Anemia

Psychiatric
___ Anxiety
___ Depression
___ Panic attacks

Allergies
___ Seasonal
___ Adhesive
___ Latex
___ Betadine

Eyes
___ Blurred vision
___ Recent loss of vision
___ Tearing
___ Pain
___ Flashes/floaters
___ Jaw pain
___ Scalp tenderness

SIGNATURE: _____ DATE: _____

Physician Signature_____