PATIENT MEDICAL HISTORY

Sun State Eye Care

TODAY'S DATE: _____

PATIENT NAME: _____
Last First Middle Initial

Do you have problems with any of these body systems?

Gastrointestinal (ulcers, digestive, reflux) Y/N?
Ear/Nose/Throat (sinus) Y/N?
Respiratory (asthma, COPD) Y/N?
Mental (memory, depression) Y/N?
Blood (cholesterol, anemia) Y/N?
Immunological (Lupus, Crohn's) Y/N?
Nervous (Parkinson's, Alzheimer's, MS) Y/N?
Genitourinary (prostate, kidney, bladder) Y/N?
Musculoskeletal (arthritis, osteoporosis) Y/N?
Skin (basal/squamous cell carcinoma) Y/N?
Endocrine (thyroid, other glands) Y/N?
Constitutional (fever, weight loss/gain) Y/N?

Do you or members of your family have:

	PERSONAL	FAMILY
Hypertension (high blood pressure)	Y/N?	Y/N? _____
Heart Disease (heart attack, blockage, irregular beats)	Y/N?	Y/N? _____
Vascular Disease (stroke, TIA, poor circulation)	Y/N?	Y/N? _____
Diabetes Mellitus (Type 1 or Type 2)	Y/N?	Y/N? _____
Date of Onset _____		
Glaucoma	Y/N?	Y/N? _____
Date of Onset_____		
Macular Degeneration	Y/N?	Y/N? _____
Cataract	Y/N?	Y/N? _____
Amblyopia (lazy eye)	Y/N?	Y/N? _____
Strabismus (eye turn)	Y/N?	Y/N? _____

Have you had any eye surgeries? Y/N _____

Have you had any eye injuries? Y/N _____

Major Surgeries? Y/N _____

Other medical problems? Y/N _____

Do you drive? Y/N _____

Do you use tobacco products? Y/N

Former smoker? Y/N

Do you drink alcohol? Y/N

Occupation? _____

Retired? Y/N

Are you allergic to any medications? Y/N

If yes, please specify _____

PLEASE LIST ALL CURRENT MEDICATIONS ON BACK SIDE (or provide list to be copied).

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