Dr. Black's eye associates

(888) EYE-CARE
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# MEDICAL HISTORY

Patient Name:_____ Date:_____

Email Address:_____Emergency Contact:_____

Pharmacy:_____ Primary Care Physician_____

Date of Birth:_____ Date of Last Eye Exam:_____

Ethnicity: Hisp____ Non Hisp____ Preferred Language: English / Other_____ Race:_____

Do you wear contacts? ❑ Yes ❑ No Do you wear glasses? ❑ Yes ❑ No

## Eye Symptoms

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Blurred Vision | | | Burning | | | Discharge | | | Flashes of Light | | |
| Loss of Vision | | | Tearing | | | Pain | | | Floaters or Spots | | |
| Redness | | | Itching | | | Dry Eyes | | | Glare or Halos | | |

Other _____

## Review of Systems - Please answer YES or NO for each question

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Fatigue | | | Shortness of Breath | | | Heat Intolerance | | | Joint Pain | | |
| Fever | | | Chest Pain | | | Increased Thirst | | | Joint Swelling | | |
| Hearing Loss | | | Irregular Heartbeat | | | Increased Urination | | | Muscle Weakness | | |
| Congestion | | | Abdominal Pain | | | Dizziness | | | Bleeding/Bruising | | |
| Sore Throat | | | Nausea | | | Depression | | | Food Allergies | | |
| Cough | | | Cold Intolerance | | | Rash | | | Seasonal Allergies | | |

## Please List medications you are currently taking (including eye medications)

| Medication Name | Dosage | Medication Name | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you allergic to any medications? YES____ NO_____ If YES:_____

## Ocular History - Please answer YES or NO for each question

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cataracts | | | Macular Degeneration | | | Injury | | | Crossed/ Lazy Eye | | |
| Glaucoma | | | Retinal Detachment | | | Surgery | | | Laser Treatments | | |

Eye Surgery or Other Procedure:_____

## Medical History - Please answer YES or NO for each question

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ENT/Sinus | | | Diabetic ____yrs. | | | Kidney Disease | | | Cancer | | |
| Migranes | | | High Blood Pressure | | | Lung Problems | | | Thyroid | | |
| Arthritis | | | Skin Disorders | | | Heart Disease/Stroke | | | Immune Disorders | | |

Surgery/Other Procedures:_____

## Family History - Please answer what applies directly to First Generation Relatives (Mother, Father, Sister, Brother)

Cataracts: YES____ Relation_____Glaucoma: YES____ Relation_____ Diabetes: YES____ Relation_____

Macular Degeneration: YES____ Relation_____ Retinal Detatchment: YES____ Relation_____

## Social History - Please answer YES or NO and fill out any other information

Do you smoke? YES____ NO____ Packs a Day/Years:_____ Former Smoker? YES____ NO____

Are you at risk for falls? YES____ NO ____ How many falls in the last year? ___ Did the fall result in injury? YES___NO___