PATIENT MEDICAL HISTORY

Do you have a family doctor YES or NO? If yes, please list___________________________________________________

REVIEW OF SYSTEMS:  

Please mark the box if you have any of the following:

- Diabetes
- Heart Problems
- Asthma
- Thyroid
- High Blood Pressure
- Cholesterol
- Irregular Heartbeat
- Shortness of Breath
- Arthritis
- Blood Disorder
- Cancer
- Hearing Loss
- Chest Pain
- Wheezing
- Muscle/Joint pain
- Abdominal Pain
- Vomiting
- Sinus Problem
- Stroke/TiAs
- Cough
- Dry Skin
- Anxiety
- Diarrhea
- Sore Throat
- Urinary Problems
- Fever
- Rash
- Depression
- Rosacea

Other, please specify:____________________________________________________________________________________

_______________________________________________________________________________________________________

Explain any problems checked above:_______________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

FAMILY HISTORY:  

Do any medical or eye diseases run in your family? Circle YES or NO. If yes, please circle all that apply:

GLAUCOMA  CATARACTS  MACULAR DEGENERATION  CANCER

DIABETES  HEART DISEASE  HIGH BLOOD PRESSURE  OTHER:____________________________________________________

SOCIAL HISTORY:  

Do you smoke/ use tobacco? (Circle One) YES or NO. If yes, how much?________________

Do you drink alcohol? (Circle One) YES or NO. If yes, how much?____________________

List ALL MEDICATIONS (including eye medications) you are currently taking. (We will be happy to copy your list, if you have one.) Please include prescription and over-the-counter medications; including vitamins, pain relievers, herbal remedies, etc.

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

HAVE YOU EVER TAKEN FLOMAX? YES or NO (ARE YOU TAKING IT NOW? YES or NO)

List any/All Eye Surgeries/Diseases/Traumas you have had:

______________________________________________________________________________________________________

______________________________________________________________________________________________________

List All Surgeries (excluding eye):

______________________________________________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

Any Allergies to Food and/or Drugs: (Circle One) YES or NO. If yes, please list:______________________________

Are you allergic to Adhesive Tape? (Circle One) YES or NO

Are you allergic to any Latex? (Circle One) YES or NO

Are you CLAUSTROPHOBIC? (Circle One) YES or NO

Do you have Sleep Apnea? (Circle One) YES or NO

SIGNATURE:________________________________________________________ DATE:________________________

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