PALMETTO CATARACT & EYE SPECIALISTS

MEDICAL HISTORY FORM 1/2

EYE HISTORY

Reason for exam	Last eye exam

Do you wear glasses? Y / N	Do you wear contact lens? Y / N If yes, specify type/brand

Have you been diagnosed with any of the following? (circle your answer)

Y / N Cataract	Y / N Amblyopia/lazy eye	Y / N Diabetes
Y / N Glaucoma	Y / N Macular degeneration	Y / N Blindness
Y / N Dry eyes	Y / N Retinal detachment	Y / N Eye Infection

Other (please specify):

Have you had any prior eye surgeries, including lasers?

List any eye drops you are using (with frequency)

MEDICAL HISTORY

List any medication allergies **If none, write 'none'**	**Latex allergy? Y / N**

Have you been diagnosed with any of the following? (circle your answer)

Y / N Diabetes	Y / N Asthma	Y / N Rosacea
Y / N High blood pressure	Y / N Emphysema/COPD	Y / N Psoriasis
Y / N High cholesterol	Y / N Cancer	Y / N Arthritis
Y / N Heart disease	Y / N Kidney disease	Y / N Bleeding disorder
Y / N Irregular heart beat	Y / N Heartburn/ulcers	Y / N Hepatitis
Y / N Stroke	Y / N Thyroid problems	Y / N HIV

List any other medical diagnosis:

List any previous surgeries:

Medications (list with dosage and frequency):

Pharmacy Name	Address	Phone #

PHYSICIANS

Primary Care Physician	Address	Phone #

Referring Physician (if different)	Address	Phone #

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MEDICAL HISTORY FORM 2/2

SOCIAL HISTORY

Do you currently smoke?	Y / N	If so, how much? _____	pack/day.
Have you smoked in the past?	Y / N	When did you quit?	_____
Any alcohol use?	Y / N	How many per week?	_____
Illicit drug use?	Y / N	What type?	_____

Are you pregnant or planning? Yes / No / NA

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following? (circle your answer; if yes, list family members)

Y / N	Blindness _____	Y / N	Diabetes _____
Y / N	Cataracts _____	Y / N	High blood pressure _____
Y / N	Glaucoma _____		
Y / N	Macular degeneration_____	Other:	
Y / N	Lazy eye _____		

REVIEW OF SYSTEMS - Do you have any of the following? (Circle)
If none, circle 'None of the above'

EYES:	Pain / Double Vision / Dry Eyes / Flashes / Floaters	/ None of the Above
EARS, NOSE, THROAT:	Hard of hearing / Ringing in Ears / Vertigo	/ None of the Above
CARDIOVASCULAR:	Chest Pain / Dizziness / Fainting Spells / Shortness of Breath Irregular Heartbeat / Difficulty Laying Flat	/ None of the Above
GENERAL:	Fatigue / Fever / Weight gain or loss	/ None of the Above
RESPIRATORY:	Cough / Congestion / Wheezing / Asthma / COPD	/ None of the Above
GASTROINTESTINAL:	Heartburn / Nausea / Vomiting / Hepatitis	/ None of the Above
GENITO-URINARY:	Pain / Difficulty / Blood in Urine / Kidney Stones / STDs	/ None of the Above
PSYCHIATRIC:	Anxiety / Mood swings / Difficulty sleeping	/ None of the Above
ENDOCRINE:	Increased thirst / hunger / urination / sweating	/ None of the Above
BLOOD/LYMPH NODES:	Easy bruising / gum bleeding / prolonged bleeding / Heavy Aspirin Use	/ None of the Above
MUSCULOSKELETAL:	Stiffness / Arthritis / Joint Pain / Swelling	/ None of the Above
SKIN:	Rash / Sores / Lesions / Hives / Eczema	/ None of the Above
NEUROLOGICAL:	Seizures / Weakness / Paralysis / Numbness / Tremors	/ None of the Above
IMMUNOLOGIC:	Hives / Itching / Runny Nose / Sinus Pressure	/ None of the Above

The information above is accurate to the best of my knowledge.

Patient's / Guardian's Signature **Date**

Palmetto Cataract and Eye Specialists Use Only
I have reviewed the history. **Date**