Name:

Age: DOB: / /

Date:

Pacific Eye Associates

Patient Medical History

MEDICATIONS ☐ Aspirin ☐ Coumadin ☐ Other blood thinners

_____ _____ _____ _____

_____ _____ _____ _____

EYEDROPS _____ _____ _____ _____

MEDICATION ALLERGY ☐ None ☐ Yes (name of medication & reaction) _____

SMOKING STATUS ☐ Current ☐ Former ☐ Never ☐ Decline to provide

FAMILY HISTORY Please check any of the following that run in your family

☐ Glaucoma ☐ Macular degeneration ☐ Retinal detachments ☐ Diabetes ☐ Cancer

Affected family member ☐ Parent ☐ Sibling ☐ Offspring ☐ Other _____

PAST EYE HISTORY -- Have you ever … please check any that apply

☐ Had glaucoma or family history of it ☐ Been treated for crossed or lazy eye? ☐ Worn glasses?

☐ Contact lenses: Disinfecting System _____ Frequency of disposal _____ Wear overnight? ☐ Yes ☐ No

☐ Had LASIK/RK? ☐ Please list other eye surgeries and date(s) _____

PAST MEDICAL HISTORY -- Do you have…

☐ Diabetes since year _____
☐ Kidney problems/stones
☐ Arthritis/back problems
☐ Asthma
☐ Lung disease
☐ HIV+ / AIDS since _____
☐ None of the above

☐ Heart attack. When? _____
☐ High blood pressure
☐ Stroke.When? _____
☐ High cholesterol
☐ Cancer type _____ year _____

☐ Thyroid / Graves disease
☐ Sickle cell disease
☐ Blood transfusion
☐ Previous surgeries (non eye)
☐ Other _____
☐ Other _____

CURRENT MEDICAL CONDITIONS: please check all that apply

					Explanation of problem
1. General symptoms	☐ Fever or chills	☐ Unplanned weight loss		☐ Other	
2. Ear, Nose, Throat	☐ Sinus	☐ Cough	☐ Dry mouth	☐ Other	
3. Heart/Vascular	☐ Chest pain	☐ Leg swelling		☐ Other	
4. Lung	☐ Wheezing	☐ Short of breath	☐ Unable to lie flat	☐ Other	
5. Endocrine	☐ Thyroid	☐ Other hormone problems		☐ Other	
6. Neurologic/Psych	☐ Fainting	☐ Seizures	☐ Numbness	☐ Other	
7. Musculoskeletal	☐ Arthritis	☐ Muscle problems		☐ Other	
8. Skin/Breast	☐ Rashes			☐ Other	
9. Blood/Hematologic	☐ Blood disorder			☐ Other	
10. Allergy/Immune	☐ Allergies			☐ Other	
11. Women only	☐ Pregnant	☐ Nursing		☐ Other	
12. Gastrointestinal	☐ Stomach or intestinal problems			☐ Other	
13. Genitourinary	☐ Genital, kidney or bladder problems			☐ Other	

☐ None to the above conditions

SOCIAL HISTORY What is/was your occupation? _____

Do you drink **alcohol?** ☐ Never ☐ Occasional ☐ Daily Use(d) **IV drugs?** ☐ Yes ☐ No

Do you live ☐ Alone ☐ With family ☐ With roommates ☐ In an assisted living facility

Physician's initial _____