PACIFIC EYE INSTITUTE

MEDICAL HISTORY

Name _____ Date _____

Why are you being seen today?

_____

_____

Medications -- List all medications you are currently taking

Name of Medication Dosing Reason Prescribed

_____

_____

_____

_____

_____

Do you take FLOMAX? YES / NO

Do you take COUMADIN or another Blood Thinner? YES / NO

Do you take ASPIRIN or IBUPROFEN? YES / NO

Do you take NITROGLYCERIN? YES / NO

Have you had your FLU SHOT? YES / NO when _____

Have you had your PNEUMONIA VACCINE? YES / NO when _____

List any over-the-counter medications / vitamins

_____

_____

Allergies – Do you have an allergic reaction to anything? YES / NO

Drug / Substance / Food If so, list and type of reaction:

_____

_____

Please list all operations or surgeries and dates (include eye operations):

_____

_____

_____

_____

Please list all other hospitalization dates and reasons:

_____

_____

_____

Do you have any history of eye trauma? YES / NO

If so, when and what? _____

Have you ever had a blood transfusion? YES / NO If so, when? _____

Is there any history of bleeding problems or reactions to anesthesia? YES / NO

If so, please explain: _____

_____

Are you pregnant? YES / NO

Do you currently wear glasses? YES / NO Contact lenses? YES / NO

If yes, are your contacts SOFT LENSES / HARD LENSES / GAS PERMEABLE

PERSONAL MEDICAL HISTORY

Do you have any of the following illnesses? If so, give year diagnosed.

			YEAR				YEAR
Arthritis	YES	NO		Lupus	YES	NO	
Asthma	YES	NO		Macular Degeneration	YES	NO	
Cancer	YES	NO		Multiple Sclerosis	YES	NO	
Diabetes	YES	NO		Respiratory	YES	NO	
Glaucoma	YES	NO		Thyroid Disease	YES	NO	
Glaucoma	YES	NO		Stroke	YES	NO	
Heart Disease	YES	NO		Syphilis	YES	NO	
Hypertension	YES	NO		Other:			
Kidney Disease	YES	NO					

Symptoms: Check any of the following symptoms you are **currently** experiencing

EYES

Blurred Vision	YES	NO	Light Sensitivity	YES	NO
Blind Spots	YES	NO	Loss of Peripheral Vision	YES	NO
Distortion of Vision	YES	NO	Poor Night Vision	YES	NO
Double Vision	YES	NO	Retinopathy of Prematurity	YES	NO
Flashing Lights	YES	NO	Strabismus	YES	NO
Floaters	YES	NO	Tunnel Vision	YES	NO

Fluctuation in Vision	YES	NO	Other:	

Name _____ Date of Birth _____

CHEST

Shortness of Breath	YES	NO	Wheezing	YES	NO
Cough	YES	NO	Other:		

EARS / NOSE / THROAT

Congestion	YES	NO	Lumps or nodes in neck	YES	NO
Hearing Problems	YES	NO	Sores or lesions in mouth	YES	NO
Jaw pain while chewing	YES	NO	Other:		

HEART

Chest Pain	YES	NO	Irregular Heart Beat	YES	NO
Fainting Spells	YES	NO	Swelling in legs	YES	NO

BONES AND JOINTS

Back Pain, Stiffness	YES	NO	Joint Pain, Swelling, Redness	YES	NO

GASTROINTESTINAL

Abdominal Pain	YES	NO	Diarrhea	YES	NO
Blood or pus in Stools	YES	NO	Other:		

GENITOURINARY

Blood in Urine	YES	NO	Unexplained weight loss	YES	NO
Genital sores /lesions	YES	NO	Urgency or Frequency in urination	YES	NO
Pain with Urination	YES	NO	Other		

HEMATOLOGICAL

Excessive Bleeding	YES	NO

SKIN

Rashes	YES	NO	Redness / Sore	YES	NO

NEUROLOGICAL / PSYCH

Depression / Anxiety	YES	NO	Numbness	YES	NO
Forgetfulness	YES	NO	Trouble Speaking / Swallowing	YES	NO

Headaches	YES	NO	Weakness	YES	NO
Incoordination	YES	NO	Other:		

Name _____ Date of Birth _____

FAMILY HISTORY

These questions refer to your parents, grandparents, aunts, uncles, brothers and sisters.

Has anyone in the **FAMILY** had / has:

Blindness / Poor Vision	YES	NO	Glaucoma	YES	NO
Cataracts	YES	NO	Heart Disease	YES	NO
Diabetes	YES	NO	Hypertension	YES	NO
			Stroke	YES	NO

SOCIAL HISTORY

Do you drive? YES / NO

Do you drink alcohol? YES / NO

How often? Occasional / Social / 1 – 2 per day day / 3 – 4 per day / other

Do you smoke? YES / NO

How many packs per day? _____ or per week? _____

Have you ever smoked? YES / NO Year quit smoking _____

Have you ever used intravenous (street) drugs? YES / NO

Current living conditions: Live Alone / Nursing Home / Retirement Facility / Live with Family /

Have live-in caretaker / unknown / Other _____

Name _____ Date of Birth _____

Signature _____ Date _____

Current Pharmacy Information

Pharmacy Name _____

Address or Location _____

Phone Number _____