Medical History

It's important that we learn your history!

Tomoka Eye

PATIENT NAME	DATE OF BIRTH

PCP / PHARMACY

MEDICAL DOCTOR'S First & Last Name	Address
	Phone Number
Date Last Seen	Fax Number
PHARMACY NAME	Address
	Phone Number
	Fax Number

MEDICAL HISTORY

Allergies to Medications Y or N

If yes, please list reaction:

Please list all major operations or hospital admissions including eye surgeries and lasers with approximate dates.

PROCEDURE	DATE	PROCEDURE	DATE

Please list ALL MEDICATIONS including eye drops and herbal supplements. Name strength and dose. If you are using eye drops, write down how often you take the drops and which eye. If Medication list is attached, please check here. ☐

MEDICATION	HOW OFTEN	MEDICATION	HOW OFTEN

FAMILY

FAMILY HISTORY (please circle & list relationship)					
Blindness	Y	N	Macular Degeneration	Y	N
Glaucoma	Y	N	Other Hereditary Disease	Y	N
Cataracts	Y	N			

SOCIAL

SOCIAL HISTORY (please circle)	DO YOU?		
Drink alcohol?	Y	N	How often?
Smoke tobacco?	Y	N	How often?
Have a history of drug abuse?	Y	N	Explain
Drive?	Y	N	How often?
Have visual difficulties driving?	Y	N	Explain
Have problems with night vision?	Y	N	Explain
Wear glasses?	Y	N	How old is present RX?
Wear contacts?	Y	N	How old is present RX?

REVIEW OF SYSTEMS: Do you currently or have you ever had problems in the following areas? (Please circle & explain)

EARS / NOSE / THROAT

Hay Fever / Other	Y	N	
Sinuses	Y	N	

CARDIOVASCULAR

Angina / Chest Pain	Y	N	
Atrial Fibrillation (Afib)	Y	N	
Congestive Heart Failure	Y	N	
Coronary Artery Disease	Y	N	
Heart Attack	Y	N	
Heart Failure / Other	Y	N	
Heart Murmur	Y	N	
Heart Valve Problems	Y	N	
High Blood Pressure	Y	N	
High Cholesterol	Y	N	

RESPIRATORY / LUNG

Asthma	Y	N	
Emphysema	Y	N	
COPD	Y	N	

GASTROINTESTINAL

Reflux / Stomach Ulcer	Y	N	
Colitis / Other	Y	N	
Crohn's Disease	Y	N	

ENDOCRINE

Diabetes	Y	N	☐ Type I
A1C _____			☐ Type II
Last Blood Sugar _____			☐ Insulin
			☐ Non-Insulin
Liver Disease	Y	N	
Thyroid Disease	Y	N	

NEUROLOGIC

Dementia	Y	N	
Headache	Y	N	
Memory Disorder	Y	N	
Multiple Sclerosis	Y	N	
Neuropathy	Y	N	
Parkinson's Disease	Y	N	
Seizures	Y	N	
Stroke	Y	N	

PSYCHIATRIC

ADHD	Y	N	
Anxiety / Other	Y	N	
Autism	Y	N	
Bipolar	Y	N	
Claustrophobia	Y	N	
Depression	Y	N	
Schizophrenia	Y	N	

BLEEDING DISORDERS

Anemia	Y	N	
Blood Transfusion	Y	N	
Coumadin Use	Y	N	
Easy Bruising	Y	N	
Other Blood Thinner	Y	N	

IMMUNOLOGIC

AIDS	Y	N	
Fibromyalgia	Y	N	
Hepatitis C	Y	N	
HIV	Y	N	
Lupus / Other	Y	N	
Rheumatoid Arthritis	Y	N	

OTHER

Cancer	Y	N	
Arthritis	Y	N	
Gout	Y	N	
Hearing Loss	Y	N	
Hiatal Hernia	Y	N	
Melanoma	Y	N	
Osteoporosis	Y	N	

OTHER ILLNESSES NOT LISTED