Harris EYE CARE

MEDICAL HISTORY

Please fill out completely using black ink only.

Print Name _____ Date _____

FAMILY DOCTOR(S)

_____

_____

OCULAR HISTORY

Cataract	No	Yes
Macular Degeneration	No	Yes
Glaucoma	No	Yes
Lazy Eye	No	Yes

Other _____

PREVIOUS EYE SURGERIES

_____

_____

_____

FAMILY HISTORY

			Who?
Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____
Cancer	No	Yes	_____
Stroke	No	Yes	_____
Macular Degeneration	No	Yes	_____
Cataracts	No	Yes	_____
Glaucoma	No	Yes	_____
Lazy Eye	No	Yes	_____
Other _____	No	Yes	_____

CURRENT MEDICATIONS/DOSAGES

_____

_____

_____

_____

_____

_____

*See List

MEDICATION ALLERGIES/SENSITIVITIES

_____

_____

_____

_____

SOCIAL HISTORY

Smoking?	No	Yes	Amount ____ Yrs _____
Drinking?	No	Yes	Amount ____ Frequency ____
Caffeine?	No	Yes	Amount per day _____
Recreational Drugs?	No	Yes	Formerly _____

Occupation? _____

Please see more on back.

REVIEW OF SYSTEMS

Please circle "Y' if you *CURRENTLY* have any of the following, or "N" if you do not.

Eye Symptoms

Loss of vision	N	Y
Blurred vision	N	Y
Fluctuating vision	N	Y
Glare or light sensitivity	N	Y
Loss of side vision	N	Y
Double vision	N	Y
Dryness	N	Y
Mucous discharge	N	Y
Redness	N	Y
Sandy or gritty feeling	N	Y
Itching	N	Y
Burning	N	Y
Foreign body sensation	N	Y
Excess tearing or watering	N	Y
Eye pain or soreness	N	Y
Floaters	N	Y
Flashing lights	N	Y
Infection of eye or lid	N	Y
Tired eyes	N	Y
Drooping eyelids	N	Y

Cardiovascular

Tachycardia (rapid heartbeat)	N	Y
High Blood Pressure	N	Y
Stroke	N	Y

Endocrine

Diabetes	N	Y
Thyroid	N	Y

Integumentary

Dry Skin	N	Y
Itching Skin/Rash	N	Y

Ears, Nose, Throat

Exophthalmos (bulging eyes)	N	Y
Hearing Loss/Ringing	N	Y
Sinus Problems	N	Y
Sore Throat	N	Y

Gastrointestinal

Acid Reflux	N	Y

Neurological

Numbness of Extremities	N	Y
Multiple-sclerosis	N	Y
Balance Disturbances/Dizziness	N	Y

Musculoskeletal

Arthritis/Joint Pain	N	Y
Fibromyalgia	N	Y

Respiratory

Asthma	N	Y
Emphysema	N	Y
COPD	N	Y

Kidney/Bladder

Frequent Urination	N	Y

Psychiatric

Depressed Mood	N	Y
Anxiety	N	Y

Hematologic/Lymphatic

Lymphadenopathy (enlarged nodes)	N	Y
High Cholesterol	N	Y
Anemia		

Immunologic

Food Allergies	N	Y
Seasonal Allergies	N	Y
Hives	N	Y

Constitutional

Fever	N	Y
Weight Gain/Loss	N	Y

Cancer N Y

Infectious/Communicable Disease

HIV, AIDS, Chlamydia, etc.	N	Y

Are you pregnant or nursing? N Y

Patient Signature _____ *Date*_____