# MEDICAL HISTORY / REVIEW OF SYSTEMS

Name_____ Occupation_____ Date_____

**MEDICAL HISTORY**

What is your general health status? _____Excellent _____Good _____Fair _____Poor

List all medications you are taking._____

_____

Do you have allergies to any medications? _____Yes _____No Allergic to what?_____
What happens?_____

List all major illnesses, injuries, surgeries and/or hospitalizations within the last 10 years._____

_____

Are you pregnant? _____Yes _____No If yes, how many months?_____

**OCULAR HISTORY**

Date of last eye examination._____Do you wear eyeglasses?_____Yes _____No

Do you wear contact lenses?_____Yes _____No If yes, what type?_____

Current eyedrops_____

List all current or past eye diseases, eye injuries, or eye surgeries._____

_____

**FAMILY HISTORY** Please circle **Yes** or **No** to indicate if any member of your family has had these diseases.
(Family history includes your parents, grandparents, siblings, and your children.)

| | | Relationship To You |
|---|---|---|
| Blindness | yes / no | |
| Cataract | yes / no | |
| Glaucoma | yes / no | |
| Diabetes | yes / no | |
| High Blood Pressure | yes / no | |
| Cancer | yes / no | |
| Heart Disease | yes / no | |
| Thyroid Disease | yes / no | |
| Arthritis | yes / no | |
| Stroke | yes / no | |
| Macular Degeneration | yes / no | |
| Other Inherited Disease | yes / no | |

**SOCIAL HISTORY** (This information is a protected part of your medical record. It is confidential.
However, if you prefer, you may discuss this portion of your medical history directly with the doctor.)

Does your vision limit activities of daily living? (driving, reading, working, etc) _____Yes _____No

If yes, please describe._____

Marital Status Single _____ Married _____ Divorced _____ Widow / Widower _____

Living Arrangements
_____Live by Yourself _____Live w/ Spouse
_____Live w/ Parents _____Live w/ Children
_____Assisted Living _____Nursing Home _____Other

Employment Status
_____Employed _____Self-Employed _____Retired
_____Homemaker _____Medical Disability _____Unemployed

Do you use tobacco products? _____Yes _____No If yes, packs per week?_____
Do you drink alcohol? _____Yes _____No If yes, amount and how often?_____
Do you use illegal drugs? _____Yes _____No If yes, what type?_____

Please put a **check** next to the following **if you have ever been exposed to or infected with:**
HIV _____ Hepatitis _____ Tuberculosis _____ Chlamydia _____ Gonorrhea _____

**REVIEW OF SYSTEMS**

Please **circle Yes** or **No** to indicate if **you** currently have any problems in one or more of the following areas? If yes, please explain or describe the problem.

GENERAL / CONSTITUTIONAL **Yes / No**
(fever, weight loss or gain, tired feeling) _____

EYES **Yes / No**
(blurred vision, eye pain, discharge, etc) _____

EARS, NOSE, THROAT, MOUTH **Yes / No**
(hearing loss, ear ache, nasal congestion, chronic cough, nasal drip, dry mouth, allergies, hay fever, etc.) _____

RESPIRATORY **Yes / No**
(asthma, emphysema, chronic bronchitis, wheezing, shortness of breath, etc.) _____

CARDIOVASCULAR **Yes / No**
(diabetes, hypertension, heart problems) _____

GASTROINTENSTINAL **Yes / No**
(diarrhea, constipation, hernia, ulcers, etc.) _____

GENITOURINARY **Yes / No**
(painful urination, frequent urination, impotence, jaundice, etc.) _____

LYMPHATIC **Yes / No**
(anemia, bleeding problems, problems with blood transfusions, etc.) _____

MUSCULOSKELATAL **Yes / No**
(arthritis, joint pain, muscle pain, cramps, stiffness, swelling, etc.) _____

SKIN **Yes / No**
(pimples, warts, growths, rashes, etc.) _____

Dawn Rakich O.D._____ Date_____