Wolstan & Goldberg
Eye Associates

Date:_____

Name:_____ DOB:_____ Gender: ❑M ❑F

PATIENT MEDICAL HISTORY RECORD

Please answer the following questions about your medical status and history:

1. Please list the medications you use (if any), including aspirin, vitamins or supplements:_____

2. **Allergies**: Do you have any food or drug allergies (including latex, adhesive, shellfish, iodine)? ❑Yes ❑No
   If Yes, please list:_____

3. Have you ever had any eye diseases (e.g. glaucoma, cataract, lazy eye, retinal detachment, macular degeneration, corneal disease, etc.)? ❑Yes ❑No If Yes, please explain:_____

4. Do you wear contact lenses? ❑Yes ❑No If Yes, are your lenses: ❑Soft ❑Hard

5. If you wear glasses or contact lenses, how long have you had your current prescription?_____

6. Do you have any glare or light sensitivity (day/night)? ❑Yes ❑No If Yes, please explain:_____

7. Have you had any surgery or been hospitalized in the last five years: ❑Yes ❑No If Yes, please provide date and reason:_____

REVIEW OF SYSTEMS: Please check all conditions that you have:		**Please provide explanation:**
High Cholesterol……	❑	
High blood pressure……	❑	
Cardiovascular (e.g. heart disease, chest pain, irregular heart beat)……...	❑	
Endocrine (diabetes, thyroid)……..	❑	
Chronic fever, unexpected weight loss/gain, fatigue……..	❑	
Ear/nose/throat (e.g. hearing loss, sinus problems, sore throat, chronic cough) ….	❑	
Respiratory (e.g. asthma, emphysema)……	❑	
Gastrointestinal (e.g. heartburn, ulcer, abdominal pain, diarrhea, vomiting)……..	❑	
Urinary (e.g. kidney/bladder conditions, pain or discomfort, blood in urine)…….	❑	
Skin (e.g. rashes, excessive dryness, rosacea, skin cancer)……	❑	
Musculoskeletal (e.g. arthritis, muscle aches, joint pain, swollen joints)……	❑	
Neurologic (e.g. stroke, numbness, weakness, headaches, paralysis)…….	❑	
Psychiatric (e.g. depression, anxiety)……..	❑	
Autoimmune deficiency (e.g. lupus, rheumatoid arthritis, HIV, hepatitis)…….	❑	
Cancer……..	❑	

FAMILY HISTORY

Have your parents, grandparents, or siblings been treated for any of the following? If yes, please specify who:

❑Diabetes_____ ❑Stroke_____ ❑High Blood Pressure_____
❑Cancer_____ ❑Heart Disease_____ ❑Macular Degeneration_____
❑Glaucoma_____ ❑Lazy Eye_____ ❑Other_____

SOCIAL HISTORY

Occupation:_____

Do you drink alcohol? ❑Yes ❑No If Yes: ❑Occasional ❑1 per day ❑2-3 per day ❑4+ per day

Do you smoke? ❑Yes ❑No If Yes: ❑Occasional ❑1/2 pk/day ❑1 pk/day ❑1+ pk/day