PATIENT MEDICAL HISTORY FORM

Your medical history is important for your eye exam, since many medical conditions may affect or are related to your eyes. Also, Medicare and private insurance presently require that your complete medical history be a part of your medical record in our office.

72 Patient Name:_____ 71 **Write today's date:**_____
74 Age:___ 73 Date of Birth:_____ 75 Place of Birth:_____
76 Race:_____ 77 Sex: M F Source of history: ( ) Patient ( ) Other:_____

1 **CHIEF COMPLAINT**

Please state the main reason for your eye exam today. List all possible problems you are having with your eyes:
Main Reason:_____

2 **HISTORY OF PRESENT ILLNESS**

Regarding problems you are **currently** having with your eyes, please answer the following. Please explain any yes answers.

	Yes	No	If yes, explain
Affecting vision (blurring, double vision, discomfort with bright lights)			
Eye sensation (irritation, dryness, pain)			
Appearance of eye (redness, bulging)			
Discharge (tearing, mucus, purulent material)			
Other			

List other eye related problems:
1._____
2._____

List prior eye injuries:_____

Prior eye surgery:

Procedure	Rt/Lt	Date	Surgeon	Where

	Yes	No	Duration in months **or**	Duration in years
History of glaucoma				
History of cataracts				

CONTACTS

If you wear contact lenses, please complete this section:
Type of contact lenses: 1. Soft:___ Gas Permeable:___ Hard:___ ***and*** 2. Brand:_____
How old are your present contacts? _____days/weeks/months/years
Are you having any problems with your contacts?_____

3 **PAST MEDICAL HISTORY**

Illnesses:

__Diabetes Present treatment: _____Diet _____Oral pill _____Insulin

Approximate number of years since first discovered: _____

If you take insulin, approximate number of years taken: _____

__High blood pressure: Number of years:_____ Average BP:_____/_____

__Heart disease: __Heart attack: Dates:_____ __Congestive heart failure

__Cancer: Organ/area involved:_____ Date found:_____ Treatment:_____

Organ/area involved:_____ Date found:_____ Treatment:_____

__History of HIV/AIDS Date discovered:_____

List other medical problems:_____

_____

_____

_____

_____

Psychiatric illnesses:_____

Accidents and injuries:_____

Prior bodily surgery:

Procedure	Reason	Date	Surgeon	Where

Hospitalizations, not already described:_____

_____

_____

4 **REVIEW OF SYSTEMS**

Constitutional (General health):

List any change in weight: lbs. gained:____ lbs. lost:_____ Over how many months:_____

Recent fatigue:__ weakness:__ fever:__ Present how many: __days __weeks __months __years

4B Head:

Describe any head injury:_____ Date:_____

History of stroke? __no __yes If yes, when:_____ What body parts were effected:_____

Recent headaches: __no (if no, please skip this section) __yes

1. How long have the headaches been occurring? List number of: ____years ____months ____weeks ____days
2. About how often do they occur: _____/day _____/week _____/month _____/year
3. About how long do they last?: _____minutes _____hours _____days
4. Where are the headaches located: ____behind the eyes ____frontal area ____top of the head
   ____Rt ____Lt ____both side(s) of the head
5. How intense are the headaches: _____mild _____moderate _____severe
6. Describe the headache: _____steady ache _____throbbing _____other_____
7. List any activities associated with the headaches:_____
8. More common at any given time of day? __no __yes If yes, when_____
9. Associated symptoms: __none __nausea __dizziness __other:_____
10. What helps the headache? __nothing, they go away on their own __dark room __rest __sleep
    medication (what kind)_____

Please check yes or no next to any area in which you have experienced or are experiencing a change or a problem. Circle any condition that applies. Further explain any condition circled on the lines provided.

Yes	No	System	If yes, please circle problems and explain:
		4C. Skin (Integumentary):	rashes (where), sores (where), lumps (where), itching (where), color changes (where), change in hair or nails
		4D. Ears:	hearing impairment, ringing, aching, dizziness, infection, discharge
		4E. Nose:	nosebleeds, discharge, nasal obstruction, sinus infections, frequent colds
		4F. Mouth and throat:	hoarseness, bleeding of gums, sore tongue, frequent sore throat, dental problems
		4G. Respiratory:	cough, sputum abnormal (color, quantity), blood in sputum, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis (positive TB skin test), hoarseness
		4H. Cardiovascular:	heart trouble, high blood pressure, rheumatic fever, heart murmur, chest pain or discomfort, palpitation, shortness of breath, require head/chest elevated to sleep, swelling of ankles, date of last EKG: _____.
		4I. Gastrointestinal:	trouble swallowing, heartburn, abdominal pain, appetite abnormal, excessive thirst, nausea or vomiting, indigestion, abnormal stools, change in bowel habits, rectal bleeding or black tarry stools, hemorrhoids, diarrhea, constipation, history of jaundice or hepatitis, liver or gall bladder trouble
		4J. Urinary:	frequent urination, frequent night urination, burning or pain on urination, blood in urine, reduced urinary stream, hesitancy, incontinence, urinary infections, urinary stones
		4K. Genitoreproductive: 1. Male:	hernias, lesions on penis, testicular pain/masses, history of venereal disease and tx
		2. Female:	menstrual problems, menopausal problems, vaginal problems, history of venereal disease and tx , # abortions:_____, # of pregnancies:_____, # of deliveries:_____, pregnancy complications
		4L. Musculoskeletal:	muscle or joint pains, stiffness, arthritis (rheumatoid, osteo, other), gout, backache
		4M. Neurological:	fainting (when), blackouts (when), seizures, weakness (of what), paralysis (of what), numbness (of what), tingling (of what), tremors (of what), memory problems
		4N. Blood disorder (hematologic/lymphatic):	anemia, easy bruising/bleeding, transfusion reaction
		4P. Endocrine:	thyroid trouble (goiter), lumps, heat or cold intolerance, excessive sweating, excessive thirst/hunger
		4R. Allergic/ immunologic:	seasonal or food allergies, hayfever, hives
		4S. Psychiatric:	nervousness, tension, mood abnormalities, depression, other:
		4T. All others negative	

Additional comments:_____

5 **PAST FAMILY HISTORY**

Please include any history of glaucoma, crossed eyes, retinal problems, cataracts, blindness and diabetes.

Parents:

Mother: Alive:__Yes __No Present age or age at death:_____ Cause of death:_____

Eye disease_____ Medical problems:_____

Father: Alive:__Yes __No Present age or age at death:_____ Cause of death:_____

Eye disease_____ Medical problems:_____

Sisters and Brothers: Please list all siblings.

Sister	Brother	Present age	Age at death	Cause of death	Eye disease	Medical Problems

Children: Please list all children.

Female	Male	Present age	Age at death	Cause of death	Eye disease	Medical Problems

Grandparents:

Maternal Grandmother: Eye disease:_____ Medical problems:_____

Maternal Grandfather: Eye disease:_____ Medical problems:_____

Paternal Grandmother: Eye disease:_____ Medical problems:_____

Paternal Grandfather: Eye disease:_____ Medical problems:_____

6 **PSYCHOSOCIAL:** Marital Status: Single Married Separated Divorced Widowed

Present and prior occupations:_____

Home situation: __House __Apt. __Other (describe):_____

Live with: __Alone __Spouse __Children (#)_____ __Other:_____

Tobacco use: __I do not use any tobacco __I use the following (check all that apply):

Type: __Cigarettes __Pipe __Chewing

Amount: _____packs of cigarettes/day __Other (describe):_____

Duration: Age begun:_____ __Still use **or** Age quit:_____ Total years of use:_____

Alcohol use: ___none _____oz/day _____oz/week _____beers/day _____beers/week

8/9 **MEDICATIONS:** Please list all medications.

Date started	Date discontinued	Name of Medication (medications currently taking)	# mg per tablet	# tablets per dose	# doses per day

7 **ALLERGIES TO MEDICATIONS:**_____

Physician Signature - James W. Matthews, M.D._____