

MILWAUKEE EYE CARE ASSOCIATES – PATIENT MEDICAL HISTORY FORM

Mr. Mrs. Ms. Dr. Other _____

Name _____ Date of Birth ____/____/____

Primary Care Physician _____

Please check any of the following medical conditions with which you have been diagnosed and list the year(s):

- Arthritis Migraine Headache Thyroid Condition Stroke
- Asthma High Blood Pressure High Cholesterol Cancer
- Diabetes Emphysema Heart Condition Other

List major surgeries or illnesses: _____

Are you ALLERGIC to any medications? YES NO Please List: _____

Are you ALLERGIC to latex? YES NO

Please list the MEDICATIONS you are currently using (including eye drops and over-the-counter medicines):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently have any of the following problems?

- Anemia Dry Throat, Mouth Irregular Heartbeat Severe itching
- Anxiety Fever Joint Pain Shortness of Breath
- Bladder infections Hard of Hearing Kidney Problems Skin Sores
- Chest Pains Hay Fever Muscle Pain Ulcers
- Depression Heartburn Seasonal Allergies Weight Loss
- Dizziness Headaches Seizures Wheezing

Do you smoke? No Yes How much? _____ Use alcohol? No Yes How much? _____

Occupation (or former): _____ Marital Status: Single Married Divorced Widow(er)

Are you a licensed driver? Yes No

Do you have a family history of any of the following conditions? Please check all that apply:

- Diabetes Cancer High Blood Pressure Heart Disease Other _____

Is there anything else about your medical history that is important for the doctor to know? Yes No Explain:

Patient Signature

Date

THIS SIDE FOR OFFICE USE ONLY

Name _____ Date of Birth ____ / ____ / ____

OCULAR HISTORY

Glasses? Yes No Distance Reading Bifocals

Contact Lenses? Soft disposable Soft conventional RGP Extended wear - How long? _____

Ocular Past Medical History

- Amblyopia/Lazy Eye
- Cataract
- Crossed Eyes
- Diabetic Retinopathy
- Dry Eyes
- Glaucoma
- Infections of eye or lid
- Injuries
- Macular Degeneration
- Retinal Detachment
- Retinal Disease
- Other

Family Ocular Medical History (Note family member.)

- Glaucoma
- Macular Degeneration
- Diabetic Retinopathy
- Cataract
- Retinal Detachment
- Other: _____

Medical History Updates

Date	Dr.'s initials	Date	Dr.'s initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Summary of Medical/Ocular History:

Diabetes Diagnosed in _____ IDDM in _____

Name of treating physician: _____

Previous Surgeries/Laser Treatments/Ocular Diseases:

Date	RIGHT EYE	MD	Date	LEFT EYE	MD
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Provider Signature

Date