MILWAUKEE EYE CARE ASSOCIATES – PATIENT MEDICAL HISTORY FORM

Name _____ *Date of Birth* / /

Primary Care Physician _____

*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):*

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

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

☐ Arthritis	☐ Migraine Headaches	☐ Thyroid Condition	☐ Stroke
☐ Asthma	☐ High Blood Pressure	☐ High Cholesterol	☐ Cancer
☐ Diabetes	☐ Emphysema	☐ Heart Condition	☐ Other

*Major surgeries or illnesses:*_____
_____
_____

*Please review and indicate whether you have had any of these **persistent symptoms** for a **few months or more**:*

SYSTEM	**Do you have any of these problems?**	**Circle One**	_____	_____	_____	_____
Eyes	blurred vision, eye pain, redness…	Yes No	Yes No	Yes No	Yes No	Yes No
General	fever, weight loss/gain, fatigue…	Yes No	Yes No	Yes No	Yes No	Yes No
ENT	stuffy nose, dry mouth, hearing loss…	Yes No	Yes No	Yes No	Yes No	Yes No
Cardiovascular	chest pain, palpitations…	Yes No	Yes No	Yes No	Yes No	Yes No
Respiratory	cough, shortness of breath, snoring…	Yes No	Yes No	Yes No	Yes No	Yes No
GI	nausea, diarrhea, constipation, reflux	Yes No	Yes No	Yes No	Yes No	Yes No
Genital, Kidney	painful/frequent urination, discharge	Yes No	Yes No	Yes No	Yes No	Yes No
Muscle, Bones	joint pain, stiffness, swelling, cramps	Yes No	Yes No	Yes No	Yes No	Yes No
Skin	sores, rash, growths, redness, itching…	Yes No	Yes No	Yes No	Yes No	Yes No
Neurological	numbness, headaches, seizures, falls…	Yes No	Yes No	Yes No	Yes No	Yes No
Psychiatric	anxiety, depression, insomnia…	Yes No	Yes No	Yes No	Yes No	Yes No
Endocrine	heat/cold sensitivity	Yes No	Yes No	Yes No	Yes No	Yes No
Blood, Lymph	swollen glands, easy bruising…	Yes No	Yes No	Yes No	Yes No	Yes No
Immunologic	allergies, hives, frequent infections…	Yes No	Yes No	Yes No	Yes No	Yes No
Females only	Are you pregnant? Nursing?	Yes No	Yes No	Yes No	Yes No	Yes No

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**_____

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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: _____

Summary of Medical/Ocular History:

☐ Diabetes Diagnosed in_____ ☐ IDDM in_____

Name of treating physician: _____

Medical History Updates

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

Previous Surgeries/Laser Treatments/Ocular Diseases:

Date	*RIGHT EYE*	MD	Date	LEFT EYE	MD

Provider Signature **Date**