



MILWAUKEE EYE CARE  
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     Diabetes     Migraine Headaches     Thyroid Condition     Heart Condition     Stroke  
 Asthma     Emphysema     High Blood Pressure     High Cholesterol     Cancer     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									
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
EYES	blurred vision, eye pain, redness...										
GENERAL	fever, weight loss/gain, fatigue...										
ENT	stuffy nose, dry mouth, hearing loss...										
CARDIOVASCULAR	chest pain, palpitations...										
RESPIRATORY	cough, shortness of breath, snoring...										
GI	nausea, diarrhea, constipation, reflux										
GENITAL, KIDNEY	painful/frequent urination, discharge										
MUSCLE, BONES	joint pain, stiffness, swelling, cramps										
SKIN	sores, rash, growths, redness, itching...										
NEUROLOGICAL	numbness, headaches, seizures, falls...										
PSYCHIATRIC	anxiety, depression, insomnia...										
ENDOCRINE	heat/cold sensitivity										
BLOOD, LYMPH	swollen glands, easy bruising...										
IMMUNOLOGIC	allergies, hives, frequent infections...										
FEMALES ONLY	Are you pregnant? Nursing?										

Do you smoke?  YES  NO How much?: \_\_\_\_\_ Use alcohol?  YES  NO How much?: \_\_\_\_\_

Occupation (or former): \_\_\_\_\_ Martial 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**

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

**Family Ocular Medical History**

(Note family member.)

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

Notes:

**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: \_\_\_\_\_