



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...	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?  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

Date	Dr.'s Initials	Date	Dr.'s Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Summary of Medical/Ocular History:**

Diabetes Diagnosed in \_\_\_\_\_  IDDM in \_\_\_\_\_ Name of treating physician: \_\_\_\_\_

**Plaquenil Use?**  Yes  No If yes, for diagnosis \_\_\_\_\_ Started in \_\_\_\_\_

**Shingles Vaccines (2 doses)?**  Yes  No If no, why? \_\_\_\_\_

**Pneumonia Vaccines?**  Yes  No

**PREVIOUS SURGERIES/LASER TREATMENTS/OCULAR DISEASES:**

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

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_