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									
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

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:** _____