

Reviewed: \_\_\_\_\_  
\_\_\_\_\_

**OFFICE PARK EYE CENTER  
MEDICAL HISTORY FORM**

Date: \_\_\_\_\_

Phone (H): \_\_\_\_\_

(W): \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of

Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: M / F Family Medical Doctor: \_\_\_\_\_

**MEDICAL HISTORY:** Have you ever been treated for any medical conditions? Please circle all that apply.

- |                     |           |             |
|---------------------|-----------|-------------|
| Diabetes            | Heart     | Cancer      |
| Lung Disease/Asthma | Stroke    | Thyroid     |
| High Blood Pressure | Arthritis | Other _____ |

**PRIOR SURGERIES:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS (con't)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DRUG ALLERGIES:** \_\_\_\_\_

**FAMILY/SOCIAL HISTORY:** Circle any diseases that run in your family

- |                     |                      |                   |
|---------------------|----------------------|-------------------|
| Diabetes            | Stroke               | Crossed Eyes      |
| High Blood Pressure | Cataracts            | Lazy Eye          |
| Cancer              | Glaucoma             | Other Eye Disease |
| Heart Disease       | Macular Degeneration |                   |

Occupation \_\_\_\_\_ Retired \_\_\_\_\_ Hobbies \_\_\_\_\_

Do you drive? Yes / No      Do you smoke? Yes / No      Do you drink alcohol? Yes / No

Do you live alone? Yes / No      If not, do you live with family, friend, rest home, other \_\_\_\_\_

**REVIEW OF SYSTEMS:** Yes No If YES, please explain:

- Do you currently have any of the following problems:
- Chronic fever, unexpected weight loss/gain, fatigue .....  .....  \_\_\_\_\_
  - Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat) .....  .....  \_\_\_\_\_
  - Heart problems (e.g. chest pain, irregular heart beat) .....  .....  \_\_\_\_\_
  - Respiratory problems (e.g. shortness of breath, wheezing, coughing) .....  .....  \_\_\_\_\_
  - Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting) .....  .....  \_\_\_\_\_
  - Urinary problems (e.g. pain or discomfort, blood in urine) .....  .....  \_\_\_\_\_
  - Skin problems (e.g. rashes, excessive dryness) .....  .....  \_\_\_\_\_
  - Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints) .....  .....  \_\_\_\_\_
  - Neurologic problems (e.g. numbness, weakness, headaches, paralysis) .....  .....  \_\_\_\_\_
  - Psychiatric problems (e.g. depression, anxiety) .....  .....  \_\_\_\_\_