MEDICAL INFORMATION FORM **DATE: _____**

NAME: _____ DOB: _____ AGE: _____ SEX: M F

PLEASE CHECK IF ANY OF THE FOLLOWING APPLY TO YOU AND THE DATE IT FIRST OCCURRED:

MEDICAL PROBLEM	Y	N	DATE	
ALZHEIMER'S				
ARTHRITIS				
ASTHMA / COPD / BRONCHITIS				
BLOOD DISORDERS (TYPE)				
BLOOD TRANSFUSION				
BOWEL DISORDERS				
CANCER (TYPE)				
DEPRESSION				
DIABETES (TYPE)				
HIGH BLOOD PRESSURE				
HEAD INJURY				
HEART DISEASE				
HEPATITIS / JAUNDICE				
HIV POSITIVE / AIDS				
KIDNEY DISEASE				
LOSS OF CONSCIOUSNESS				
LUPUS				
MIGRAINE HEADACHES				
NERVOUS DISORDER				
PSORIASIS				
RAYNAUD'S DISEASE				
RHEUMATIC FEVER				
SARCOIDOSIS				
SEIZURES				
STROKE				
SYPHILLIS / GONORRHEA / VD				
THYROID DISEASE				
TUBERCULOSIS				

PLEASE LIST ANY SURGERY (OTHER THAN EYE SURGERY) AND DATES:

_____
_____
_____
_____
_____
_____

PLEASE LIST ALL CURRENT MEDICATIONS/DOSE:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

OTHER MEDICAL PROBLEMS:

_____
_____

ALLERGIES TO MEDICATIONS:

_____
_____

WHO IS YOUR PRIMARY CARE DOCTOR?

_____

WHO IS YOUR OPTOMETRIST (IF ANY)?

_____

OCULAR HISTORY:

	Y	N
Amblyopia / Lazy Eye	[ ]	[ ]
Cataract	[ ]	[ ]
Corneal Disease	[ ]	[ ]
Dry Eye	[ ]	[ ]
Glaucoma	[ ]	[ ]
Herpes	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Retinal Detachment	[ ]	[ ]
Other _____	[ ]	[ ]

LIST ANY EYE SURGERIES AND DATE(S):

_____
_____
_____
_____

Do you use Tobacco? Yes (4004F) No (1036F)

Cigarettes or Smokeless

Did you receive a Pneumonia Vaccine?

Yes (4040F) No (4040F-8P)
When? Month/Year _____

Did you receive a Flu Vaccine?

Yes (G8482) No (G8493F)

When? Month/Year _____

MEDICAL REVIEW OF SYSTEMS

Do you currently have any problems in the following areas:

CONSTITUTIONAL	**YES**	**NO**
Fever	[ ]	[ ]
Weight loss or gain	[ ]	[ ]
Fatigue	[ ]	[ ]
EYES		
Loss of vision	[ ]	[ ]
Loss of side vision	[ ]	[ ]
Distorted vision or halos	[ ]	[ ]
Fluctuating vision	[ ]	[ ]
Flashes	[ ]	[ ]
Floaters	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]
Light sensitivity	[ ]	[ ]
Double vision	[ ]	[ ]
Crossing or drifting of eyes	[ ]	[ ]
Redness	[ ]	[ ]
Discharge	[ ]	[ ]
Foreign-body sensation	[ ]	[ ]
Sandy or gritty feeling	[ ]	[ ]
Dryness	[ ]	[ ]
Itching	[ ]	[ ]
Burning	[ ]	[ ]
Excess tearing/watering	[ ]	[ ]
Glare	[ ]	[ ]
Styes	[ ]	[ ]
Other _____		
EARS, NOSE, MOUTH, THROAT		
Hearing difficulty	[ ]	[ ]
Ringing or Vertigo	[ ]	[ ]
Sinus congestion	[ ]	[ ]
Runny nose	[ ]	[ ]
Post-nasal drip	[ ]	[ ]
Nosebleeds	[ ]	[ ]
Dry throat / mouth	[ ]	[ ]
Hoarseness	[ ]	[ ]
RESPIRATORY (LUNGS/BREATHING)		
Cough	[ ]	[ ]
Shortness of breath	[ ]	[ ]
Wheezing	[ ]	[ ]
CARDIOVASCULAR		
Chest pain or palpitations	[ ]	[ ]
Other _____	[ ]	[ ]

GASTROINTESTINAL	**YES**	**NO**
Swallowing difficulty	[ ]	[ ]
Vomiting / Heartburn	[ ]	[ ]
Diarrhea / Constipation	[ ]	[ ]
Jaundice	[ ]	[ ]
Blood in stools / black stools	[ ]	[ ]
GENITOURINARY		
Urinary frequency	[ ]	[ ]
Urinary pain or blood	[ ]	[ ]
Males –		
Discharge, lesions, masses	[ ]	[ ]
Females –		
Currently pregnant	[ ]	[ ]
Breast masses or discharge	[ ]	[ ]
Vaginal bleeding, discharge	[ ]	[ ]
MUSCULOSKELETAL		
Joint pain, swelling	[ ]	[ ]
Redness	[ ]	[ ]
Muscle pain or cramps	[ ]	[ ]
SKIN		
Rashes or color changes	[ ]	[ ]
Itching or dryness	[ ]	[ ]
Hair or nail changes	[ ]	[ ]
NEUROLOGICAL		
Headaches	[ ]	[ ]
Numbness or tingling	[ ]	[ ]
Weakness or paralysis	[ ]	[ ]
Fainting or blackouts	[ ]	[ ]
PSYCHIATRIC		
Anxiety	[ ]	[ ]
Depression	[ ]	[ ]
Other _____	[ ]	[ ]
ENDOCRINE		
Heat or cold intolerance	[ ]	[ ]
Excessive thirst or hunger	[ ]	[ ]
HEMATOLOGICAL / LYMPHATIC / IMMUNOLOGY		
Easy bruising / bleeding	[ ]	[ ]
Blood transfusions	[ ]	[ ]
Swollen lymph nodes	[ ]	[ ]

FAMILY HISTORY

Have you or your family members been diagnosed with:

		Relative
Glaucoma	[ ]	_____
Macular Degeneration	[ ]	_____
Diabetes	[ ]	_____
Retinal Detachment	[ ]	_____
Cataracts	[ ]	_____
Amblyopia	[ ]	_____
Strabismus	[ ]	_____

SOCIAL HISTORY	**YES**	**NO**
Are you pregnant?	[ ]	[ ]
Do you drink alcohol?	[ ]	[ ]
Do you drink coffee?	[ ]	[ ]
Do you use IV drugs?	[ ]	[ ]

I am (circle one)

Married Single Widowed Divorced

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

DATE REVIEWED: _____ PHYSICIAN: _____

REV. 04/11/02