Medical History

Name:_____ **Date:** _____

Family Physician: _____**Optometrist/Previous Eye Doctor:**_____

Cardiologist: _____**Specialist:** _____

Height:_____**Weight:** _____

Current Medications (Please list any medications including eye drops/supplements/vitamins that you take):

☐ No Current Medications ☐ See Attached List

Medication	**Dose**	**Frequency**

Are you allergic to any of the following? ☐ **No medication allergies**

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Sulfa drugs ☐ **Latex**

☐ Fluoroquinolones, such as: ofloxacin (Ocuflox), levofloxacin (Levaquin), ciprofloxacin (Cipro), moxifloxacin (Avelox, Vigamox). Please list medication and exact reaction: _____

Other: _____

Do you currently, or have you ever, taken a medication by the name of <u>Flomax</u> (generic: tamsulosin), <u>Jalyn</u> (tamsulosin/dutasteride), or <u>Rapaflo</u> (silodosin)? Have you now, or have you ever, taken any *similar* mediations such as Hytrin (terazosin), Cardura (doxazosin), Avodart (dutasteride), or Uroxatral (alfuzosin)? These are medications that some men take for prostate problems that can affect pupil dilation at the time of eye surgery. Some women may also take these medications for bladder related problems. Yes No

If you answered, "yes", please list the medication(s), when you started taking the medication(s), and when discontinued (if you are no longer on the medication) _____

Name:_____ **Date:** _____

Social History

Tobacco Use: ☐ Current every day smoker ☐ Former smoker
☐ Current some day smoker ☐ Never smoker

Type _____ How may per day:_____ How Long: _____

Alcohol Use: ☐ Yes ☐ No

Number per week: _____ Wine _____ Beer_____ Hard Liquor_____

Recreational Drugs: ☐ Yes ☐ No

Hobbies/Special Interests: _____

Medical History/Review of Systems: (Mark any of the conditions that you currently have or have had)

Diabetes: ☐ Yes ☐ No

If yes, ☐ Type I ☐ Type II (☐ insulin ☐ no insulin) Year Diagnosed: _____ Last A1C: _____

AIDS/HIV	○ Yes	○ No	Epilepsy	○ Yes	○ No	Lung Disease	○ Yes	○ No
Acid reflux	○ Yes	○ No	Fainting Spells/Dizziness	○ Yes	○ No	Melanoma	○ Yes	○ No
Alzheimer's Disease	○ Yes	○ No	Fatigue	○ Yes	○ No	Migraines	○ Yes	○ No
Anemia	○ Yes	○ No	Headaches	○ Yes	○ No	Muscle Pain	○ Yes	○ No
Anxiety	○ Yes	○ No	Heart Attack	○ Yes	○ No	Osteoporosis	○ Yes	○ No
Arthritis	○ Yes	○ No	Heart Disease	○ Yes	○ No	Pacemaker	○ Yes	○ No
Blood Clots	○ Yes	○ No	Heart Murmur	○ Yes	○ No	Panic Attacks	○ Yes	○ No
Blood Disease	○ Yes	○ No	Hepatitis	○ Yes	○ No	Psoriasis	○ Yes	○ No
Blood Transfusion	○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Recent Weight Loss	○ Yes	○ No
Bruise Easily	○ Yes	○ No	High Cholesterol	○ Yes	○ No	Renal Disease	○ Yes	○ No
Cancer	○ Yes	○ No	Hives or Rash	○ Yes	○ No	Shortness of Breath	○ Yes	○ No
Chest Pain	○ Yes	○ No	Hypoglycemia	○ Yes	○ No	Sinusitis	○ Yes	○ No
COPD	○ Yes	○ No	Incontinence	○ Yes	○ No	Stoke/TIA	○ Yes	○ No
Cough	○ Yes	○ No	Irregular Heartbeat	○ Yes	○ No	Thyroid Disease	○ Yes	○ No
Depression	○ Yes	○ No	Joint Pain	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Diabetes	○ Yes	○ No	Kidney Problems	○ Yes	○ No	Tumors or Growths	○ Yes	○ No
Diarrhea	○ Yes	○ No	Kidney Stones	○ Yes	○ No	Ulcers	○ Yes	○ No
Drug Addiction	○ Yes	○ No	Leukemia	○ Yes	○ No	Other:		
Emphysema	○ Yes	○ No	Liver Disease	○ Yes	○ No	Other:		
Environmental Allergies	○ Yes	○ No	Low Blood Pressure	○ Yes	○ No	Other:		

Family Medical History: (List family member – Mother, Father, Grandparent, Siblings)

			Affected Relative				Affected Relative
Blindness	☐ Y	☐ N		Glaucoma	☐ Y	☐ N	
Cancer	☐ Y	☐ N		Heart Disease	☐ Y	☐ N	
Cataract	☐ Y	☐ N		High Blood Pressure	☐ Y	☐ N	
Corneal Problems	☐ Y	☐ N		Macular Degeneration	☐ Y	☐ N	
Diabetes	☐ Y	☐ N		Retinal Detachment	☐ Y	☐ N	
Diabetic Eye Disease	☐ Y	☐ N		Other	☐ Y	☐ N	

Other: _____

Name:_____ **Date:** _____

Reason for Visit: (Please explain the problems that bring you to our office today.)

_____

_____

_____

_____

Surgical History

Eye Surgeries/Laser Treatments ☐ No Previous Eye Surgeries/Laser Treatments

_____

_____

_____

_____

All Other Surgeries ☐ No Previous Surgeries Approximate Date of Surgery

_____ _____

_____ _____

_____ _____

_____ _____

Fall Risk

Have you fallen two times or more in the past 12 months? ☐ Yes ☐ No

Were you injured in a fall in the past 12 months? ☐ Yes ☐ No

Recent Lab Testing/Studies

	Approximate Date	Location
Blood Work:	_____	_____
X-Ray:	_____	_____
CAT Scan:	_____	_____
MRI:	_____	_____
Other:	_____	_____