Medical History

Date:_____

Name: _____ **Date of Birth:** _____

Optometrist/Previous Eye Doctor: _____ **Date of Last Exam:** _____

Primary Care Physician:_____ **Cardiologist:** _____

Specialists: _____

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

☐ No Current Medications ☐ See Attached List ☐ See back of page

Medication	**Dose**	**Frequency**

Do you currently take Amiodarone (Pacerone) or Citalopram (Celexa)? ☐ **YES** ☐ **NO**

Do you have any arm restrictions (Blood pressure or IV): ☐ Yes ☐ No

If "yes", which arm **CAN** we use for blood pressures or IV: _____

Are you allergic to any of the following?

☐ Fluoroquinolones, such as: ofloxacin (Ocuflox), levofloxacin (Levaquin), ciprofloxacin (Cipro), moxifloxacin (Avelox, Vigamox).

Reaction: _____

☐ NSAIDS (non-steroidal anti-inflammatory drugs), such as: Celebrex, Motrin, Advil, Toradol, Aleve, Naproxen, etc.

Reaction: _____

☐ Local Anesthetics ☐ Sulfa drugs ☐ Latex ☐ Iodine

Reaction: _____

Please list any other medication allergies and the reaction: ☐ **No medication allergies**

Medication Allergy	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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): _____

when discontinued (if you are no longer on the medication): _____

<u>Medical History/Review of Systems:</u> (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: _____

Pacemaker? ☐ Yes ☐ No

History of TIA, Stroke, Heart Attack, or Stent Placement? ☐ Yes ☐ No

If "yes", When? _____ Within the last 3 months? ☐ Yes ☐ No

Constitutional		Cardiovascular		Respiratory		Endocrine	
X	Please Mark	X	Please Mark	X	Please Mark	X	Please Mark
	No Issues		No Issues		No Issues		No Issues
	Fatigue		Angina		COPD		Increased Thirst
	Malaise		Heart Attack		Wheezing		Low Blood Sugar
	Chills		High Cholesterol		Cough		Diabetes; diet
	Fever		High BP		Asthma		Diabetes; oral
	Night Sweats		Low BP		Tuberculosis		Diabetes; insulin
	Appetite Changes		Murmur		Shortness of Breath		Hypothyroid
	Weight Changes		Blood clots	**HEENT**			Hyperthyroid
Gastrointestinal			Varicose Veins	X	Please Mark		Goiter
X	Please Mark	**Genitourinary**			No Issues		Heat/Cold Intolerance
	No Issues	X	Please Mark		Head Injury	**Neurological**	
	Diarrhea		No Issues		Hearing loss	X	Please Mark
	Constipation		Blood		Earache		No Issues
	Stool Changes		BPH		Hay fever		Alzheimer's
	Hemorrhoids		Difficult Urination		Sinus Pain		Dizziness
	Indigestion		Enlarged Prostate		Stuffiness		Headaches
	Hard to Swallow		Frequent Urination		Discharge		Migraines
	Nausea/Vomiting		Frequent UTIs		Dry Mouth		Multiple Sclerosis
Musculoskeletal			Incontinence		Sore Throat		Neuropathy
X	Please Mark		Kidney Stones		Dentures		Paralysis
	No Issues	**Psychiatric**			Hard to Swallow		Parkinson's Disease
	Arthritis	X	Please Mark	**Dermatological**			Seizures
	Swelling		No Issues	X	Please Mark		Stroke
	Stiffness		Depression		No Issues		TIA
	Muscle Aches		Nervousness		Rash		Tremors
	Muscle Weakness		Anxiety		Lump	**Hematological**	
	Leg Cramps		Memory Loss		Itching	X	Please Mark
	Back Pain		Panic Attacks		Dryness		No Issues
	Joint Pain		Mania				Ease of Bruising
							Excessive Bleeding
							Enlarged Lymph Nodes
							Anemia

Family Medical History: (List family member – Mother (M), Father (F), Grandparent (G), Siblings(S)

			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	

Height: _____ **Weight:** _____

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

_____ _____

_____ _____

_____ _____

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: _____

Fall Risk

Do you use a cane, walker, or other assistive device? ☐ Yes ☐ No

Have you fallen in the last 3 months? ☐ Yes ☐ No

Are you unsteady when you walk? ☐ Yes ☐ No

Recent Lab Testing/Studies

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