Medical & Ophthalmic history form

date updated ______

Name: **Date of Birth:**

Primary care physician(s):

Current medications (please list)

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________
7. ____________
8. ____________
9. ____________
10. ____________

Allergies (please list)

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________

Social history: (please check yes or no)

Yes	No			
◻	◻	Do you smoke?	How many packs per day? ________	How many years? ______
◻	◻	Do you drink alcohol?	How much & how often? ________	
◻	◻	Do you exercise?	What type & how often? ________	
◻	◻	Animal or pet contact?	Please describe ____________	

Occupation? **If retired, previous occupation?**

Residence(s) other than Hawaii?

Family History: **Does any family member have any of the following problem?**

Yes	No		
◻	◻	Diabetes	whom? ____________
◻	◻	Glaucoma	whom? ____________
◻	◻	Macular degeneration	whom? ____________
◻	◻	Retinal detachment	whom? ____________
◻	◻	Other significant eye problems? (Please list)	

Past Eye history: **Do you have any of the following eye problem, if yes, which eye & what year diagnosed?**

Yes	No	
◻	◻	Cataract
◻	◻	Glaucoma
◻	◻	Macular degeneration
◻	◻	Diabetic retinopathy
◻	◻	Retinal detachment

Please list past eye surgery (type, right/left eye, what facility, when and surgeon's name).

Review of systems

	Yes	No		Yes	No		Yes	No
Loss/gain of weight?	◻	◻	Ulcers?	◻	◻	Migraines?	◻	◻
Lack of energy?	◻	◻	Anemia	◻	◻	Depression?	◻	◻
Hearing deficit ?	◻	◻	Kidney stones?	◻	◻	Anxiety?	◻	◻
Decreased vision?	◻	◻	Dialysis?	◻	◻	Diabetes?	◻	◻
Sinus trouble?	◻	◻	Arthritis?	◻	◻	Thyroid?	◻	◻
High blood pressure?	◻	◻	Gout?	◻	◻	Cancer? (type/treatment)	◻	◻
Chest pains?	◻	◻	Rash?	◻	◻	TB?	◻	◻
Palpitations?	◻	◻	Stroke?	◻	◻	Hepatitis?	◻	◻
Asthma?	◻	◻	Seizures?	◻	◻	HIV?	◻	◻
Long standing cough?	◻	◻						

Signature ____________________ **Date**____________________