

PROVISION EYE CENTER-Medical History

Date: _____ Patient Name: First _____ Last: _____

Date of Birth _____ Phone # _____

Medical Problems: MUST BE COMPLETED - CHECK ALL THAT APPLY

- Diabetes
- Hypertension
- Heart Disease
- Thyroid
- Arthritis
- Chronic Obstructive Pulmonary Disease
- Cholesterol
- Asthma
- Major Cancer
- Bleeding Disorder
- Ulcer
- Heart Failure
- Kidney Stone
- Kidney Failure
- Stroke
- AIDS/HIV
- Cataract
- Glaucoma
- Macular Degeneration
- Dry Eyes
- Floaters/Flashes
- Diabetic Retinopathy

Other: _____ None

Allergies/Drug Reactions

Current Medications

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____ None

None **LATEX ALLERGY**

Past Surgeries:

- Mastectomy
- Appendectomy
- Cataract Surgery
- Heart Bypass
- Hernia
- Right Eye : by Whom: _____ Year _____
- Left Eye : by Whom: _____ Year _____
- Prostate
- Hysterectomy
- Glaucoma
- Lung
- Retina
- Strabismus
- LASIK

Review of Systems – Check any that apply or none if applicable

- Eye:**
- Blurred vision
 - Pain or ache
 - Watery eyes
 - Burning
 - Trouble seeing to perform recreational activity or hobby (golf, knitting, etc)
 - Floaters
 - Trouble reading
 - Red eyes
 - Itchy eyes
 - Discharge
 - Flashing Lights
 - Trouble seeing road signs
 - Haloes around lights
 - Glare from bright lights or headlights at night
 - None of the above

When was your last complete eye exam ___/___/___

Ear, Nose & Throat:

- Swollen Glands
- Chronic Cough
- Other
- None

Cardiovascular:

- History of heart attack
- Slow heart rate
- Blocked arteries
- Hypertension
- Irregular Heart Rate
- Other
- None

Respiratory:

- Shortness of breath
- Wheezing
- History of asthma
- History of emphysema
- Chronic cough
- Other
- None

Neurological / Musculoskeletal:

- Tremor
- Dementia
- Numbness
- Seizure
- History of Stroke
- Multiple Sclerosis
- Temporary loss of vision
- Joint Pain
- Muscle Aches
- None

Endocrine:

- Diabetes
- Hyperthyroid
- Hypothyroid
- None

Gastrointestinal / Skin:

- Hernia
- Rash
- Ulcer
- Other
- Lesion
- None

Allergic/Immunologic:

- Hives
- Lupus
- None

Family History of:

- Glaucoma
- Detached Retina
- Cataracts
- Macular Degeneration
- Diabetes
- Crossed Eyes
- None

Do you wear contact lenses? Yes No

Smoke Cigarettes Yes, _____ packs per day No, do not smoke

Drink Alcohol Yes, _____ per day on average None

Hobbies/ Activities: _____ Occupation _____

Lives: Alone Spouse Care Center Other _____

Primary Physician _____ Endocrinologist _____

Physician Use Only _____ Date: _____