EF 10.2

MEDICAL HISTORY / REVIEW of SYSTEMS

Date

Patient Name

DOB

What is your general health status? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List any medications you are taking. _____

_____

Do you have allergies to any medications? ☐ Yes ☐ No If yes, explain: _____

_____

Do you have general allergies? ☐ Yes ☐ No Allergic to what? _____

What happens? _____

Are you pregnant? ☐ Yes ☐ No If yes, how many months? _____

List all major illnesses, injuries, surgeries and/or hospitalizations within the last 10 years. _____

_____

Date of your last eye examination _____ Do you wear eyeglasses? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No If yes, what type? _____

Current eyedrops _____

List all current or past eye diseases, eye injuries, or eye surgeries. _____

_____

FAMILY HISTORY

Please **check** to indicate if any member of your family has had these diseases.
(Family history includes your parents, grandparents, siblings, and your children.)

	Relationship To You		Relationship To You
☐ Blindness	_____	☐ Cataract	_____
☐ Diabetes	_____	☐ Glaucoma	_____
☐ Heart Disease	_____	☐ Macular Degeneration	_____
☐ High Blood Pressure	_____	☐ Arthritis	_____
☐ Thyroid Disease	_____	☐ Stroke	_____
☐ Other Inherited Disease	_____	☐ Cancer	_____

SOCIAL HISTORY

This information is a protected part of your medical record. It is confidential. If you prefer, you may discuss this portion of your medical history directly with the doctor.

Does your vision limit activities of daily living? (driving, reading, working, etc) ☐ Yes ☐ No

If yes, please describe. _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow / Widower

Living Arrangements ☐ Live by Yourself ☐ Live with Spouse ☐ Live with Children ☐ Live with Parents ☐ Assisted Living ☐ Nursing Home

Employment Status ☐ Employed ☐ Self-Employed ☐ Retired ☐ Homemaker ☐ Medical Disability ☐ Unemployed

EF 10.2 | Patient Name | Date

Do you use tobacco products? ☐ Yes ☐ No If yes, how often? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, what type? _____

Have you ever been exposed to or infected with: ☐ HIV ☐ Hepatitis ☐ Tuberculosis

REVIEW of SYSTEMS

Please **check Yes** or **No** to indicate if **YOU** currently have any problems in one or more of the following areas? If yes, please explain or describe the problem.

GENERAL
(fever, chills, nausea, vomiting) ☐ Yes ☐ No

EYES
(blurred vision, double vision, eye pain) ☐ Yes ☐ No

EARS, NOSE, THROAT, MOUTH
(hearing loss, ear pain, nosebleeds, nasal congestion, allergies, dry mouth, sore throat, mouth sores, etc.) ☐ Yes ☐ No

CHEST
(shortness of breath, asthma, chronic bronchitis, chronic cough, lumps, masses) ☐ Yes ☐ No

CARDIOVASCULAR
(high blood pressure, high cholesterol, chest pain, fast or irregular heartbeats) ☐ Yes ☐ No

GASTROINTENSTINAL
(diarrhea, constipation, hernia, ulcers) ☐ Yes ☐ No

GENITOURINARY
(frequent urination, painful urination, impotence) ☐ Yes ☐ No

MUSCULOSKELATAL
(arthritis, joint pain, joint stiffness, joint swelling, muscle pain) ☐ Yes ☐ No

NEUROLOGICAL
(numbness, tingling, weakness) ☐ Yes ☐ No

ENDOCRINOLOGY
(diabetes, thyroid problems) ☐ Yes ☐ No

LYMPHATIC
(bleeding problems, anemia, tumors) ☐ Yes ☐ No

SKIN
(rashes, redness, pimples, growths) ☐ Yes ☐ No

Doctor's Signature _____ **Next Test** _____