



COMPREHENSIVE EYECARE PHYSICIANS, P.C.

PATIENT MEDICAL HISTORY

TODAY'S DATE: _____

NAME: _____

BIRTHDATE: _____

GENDER: MALE FEMALE

OCCUPATION: _____

PRIMARY CARE DOCTOR/INTERNIST: _____

PAST OCULAR HISTORY

Have you had: (please circle)

Laser eye surgery **NO** **YES** _____

Surgery for either eye **NO** **YES** _____

Eye injury **NO** **YES** _____

Eye Infection **NO** **YES** _____

REVIEW OF SYSTEMS - Please explain all "YES" answers

Have you had problems with: (please circle)

Fever, weight loss, fatigue **NO** **YES** _____

Rashes/other skin problems **NO** **YES** _____

Head Trauma **NO** **YES** _____

Headache **NO** **YES** _____

Ears, nose or throat **NO** **YES** _____

Neck pain/surgery **NO** **YES** _____

Lungs/breathing **NO** **YES** _____

Cardiovascular

 Heart disease **NO** **YES** _____

 High blood pressure **NO** **YES** _____

Stomach/intestines **NO** **YES** _____

Liver disease **NO** **YES** _____

Kidney, bladder, genital **NO** **YES** _____

Bones/arthritis **NO** **YES** _____

Neurologic problems/stroke **NO** **YES** _____

Lymphatic system **NO** **YES** _____

Bleeding disorder **NO** **YES** _____

Psychiatric disorder **NO** **YES** _____

Diabetes **NO** **YES** How many years? _____ **TYPE 1** **TYPE 2**

Thyroid problems **NO** **YES** _____

Other (please list) _____

Are you pregnant? **NO** **YES** How far along? _____

CURRENT MEDICATIONS

Eyedrops including any over the counter:

_____	right eye	left eye	both eyes
_____	right eye	left eye	both eyes
_____	right eye	left eye	both eyes
_____	right eye	left eye	both eyes
_____	right eye	left eye	both eyes

Prescription and OTC Medications or Vitamins/Supplements:

ALLERGY HISTORY

Medication allergies	NO	YES	_____
Latex allergies	NO	YES	_____
Allergy to iodine or shellfish	NO	YES	_____
Environmental allergies	NO	YES	_____

FAMILY HISTORY

Blindness	NO	YES	_____
Glaucoma	NO	YES	_____
Macular degeneration	NO	YES	_____
Retinal detachment	NO	YES	_____
Keratoconus	NO	YES	_____

SOCIAL HISTORY

Cigarette smoker (*please circle*) **NEVER** **CURRENT** **FORMER, BUT STOPPED**

 If current, please state number of years smoking: _____

 If former, please state number of years stopped smoking: _____

Alcohol (*please circle*) **NONE** **SOCIAL** **>1 DRINK A DAY**

Reviewed on:	Date: _____	Initials: _____	Date: _____	Initials: _____
	Date: _____	Initials: _____	Date: _____	Initials: _____
	Date: _____	Initials: _____	Date: _____	Initials: _____
	Date: _____	Initials: _____	Date: _____	Initials: _____