WINSTON EYE CARE

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Patient Medical History Form

General Information

Patient Name ______________________________

Birth date ______________________________

Family Physician and/or Primary Health Care Provider:

Doctor/Other ______________ Phone ______________

Address ______________ City ______________

Present Medical History

Have you been diagnosed with or have had any of the following? Please check all that apply and indicate how many years you have had the health condition.

Cardiovascular

☐ Myocardial Infarction ☐ High Cholesterol ☐ High Blood Pressure
☐ Coronary Artery Disease ☐ Congestive Heart Failure ☐ Atrial Fibrillation
☐ Edema ☐ Pacemaker ☐ Aneurysms

Respiratory

☐ Asthma ☐ Bronchitis ☐ Tuberculosis
☐ Pneumonia ☐ Pulmonary Hypertension ☐ Sleep Apnea

Gastrointestinal

☐ Acid Reflux ☐ Hepatitis (Type: ___________) ☐ Hemorrhoids
☐ Diverticulitis ☐ Diverticulitis ☐ Polyps

Musculoskeletal

☐ Arthritis (Specify:___________) ☐ Cerebral palsy ☐ Fibromyalgia
☐ Carpal Tunnel Syndrome ☐ Muscular Dystrophy

Neurological

☐ Alzheimer’s Disease ☐ Stroke ☐ Dementia
☐ Migraines ☐ Seizures ☐ Epilepsy
☐ Multiple Sclerosis

Endocrine

☐ Diabetes (Type: ___________) ☐ Hyperglycemia ☐ Hypoglycemia
☐ Hypothyroidism ☐ Hyperthyroidism ☐ Osteoporosis

Hematologic/ Lymphatic

☐ Anemia ☐ Leukemia ☐ Hemophilia
☐ Blood Thinners

List all others: ______________________________

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Surgical History

Please fill out the table below concerning your past surgical history.

Date of Surgery	Procedure	Surgeon	Facility
____________	______________________________	______________	_______________
____________	______________________________	______________	_______________
____________	______________________________	______________	_______________
____________	______________________________	______________	_______________

Past / Present Ocular History

Have you been diagnosed with or have had any of the following? Please check all that apply and indicate how many years you have had the health condition.

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Dry Eye
- ☐ Amblyopia
- ☐ Diabetic Retinopathy
- ☐ Hemorrhages
- ☐ Glasses or contacts
- ☐ Other:____

Family History

Has anyone in your <u>family</u> (blood relatives only) been diagnosed with or have had any of the following? Please check all that apply.

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Hemorrhages
- ☐ Amblyopia
- ☐ Diabetic Retinopathy
- ☐ Cancer
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Cholesterol
- ☐ Kidney Disease
- ☐ Stroke

Other:____

Current Medications

List any prescription medications (include strength of medication) you are currently taking:

	Name	Dose	Frequency	Reason
1.				
2.				
3.				
4.				
5.				
6.				
7.				

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:

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List any drug allergies: ______________________________________

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