COASTAL EYE INSTITUTE

MEDICAL HISTORY & REVIEW OF SYSTEMS

PLEASE PRINT

Name _____ Birth Date ____/____/____ Today's Date ____/____/____

Who referred you to us? _____ Family Physician _____ Marital Status _____

Do you drink alcohol? yes no rarely *(PLEASE CIRCLE)* Do you smoke? yes no *(PLEASE CIRCLE)* Occupation _____

Are you allergic to latex, penicillin, sulfa or any other medications? yes no *If yes, please list:*

_____

_____

_____

_____

_____

Please list all current medications that you take:

_____

_____

_____

_____

_____

_____

Has any family member had:

Glaucoma? yes no _____ (list relatives)

Diabetes? yes no _____ (list relatives)

Corneal Transplant? yes no _____ (list relatives)

Retinal Detachment? yes no _____ (list relatives)

Macular Degeneration? yes no _____ (list relatives)

Other Eye Diseases? yes no _____ (list relatives)

Have you had surgery or hospitalizations ***not*** involving the eyes? yes no

If yes, please describe: _____

_____

_____

_____

DO YOU HAVE A HISTORY OF THE FOLLOWING MEDICAL PROBLEMS?

Circle Y or N		If yes, please describe
Y N	Retinal Detachment	
Y N	Glaucoma	
Y N	Arthritis / Lupus	
Y N	Cancer	
Y N	Diabetes	
Y N	Heart Attack	
Y N	Heart Disease	
Y N	High Blood Pressure	
Y N	Asthma/Emphysema	
Y N	Kidney Disease/Stones	
Y N	Stroke	
Y N	HIV/AIDS	
Y N	Bleeding Problems	
Y N	Other Illness	

DO YOU CURRENTLY HAVE PROBLEMS WITH ANY OF THE FOLLOWING?

Circle Y or N		If yes, please describe
Y N	Ears/nose/throat: i.e. dry mouth	
Y N	Heart: i.e. low blood pressure, heart failure or slow pulse	
Y N	Lungs: i.e. cough, history of TB, sarcoid or lung cancer	
Y N	General: i.e. fever or weight loss	
Y N	Psychiatric: i.e. depression	
Y N	Urinary: i.e. impotence or frequent urination	
Y N	Neurologic: i.e. migraines or memory problems	
Y N	Digestive: i.e. history of polyps, colon cancer or bloody stools	
Y N	Muscles/joints: i.e. joint swelling, prednisone or steroid use	
Y N	Blood/lymph: i.e. anemia or bleeding problems	
Y N	Urinary: i.e. urination pain, sexually transmitted disease, syphilis	

History of eye problems (including surgery or laser treatment on your eyes)? yes no *(If yes, please list all below with dates)*

Right Eye _____

_____

Left Eye _____

_____