Pasadena EYE CENTER

Patient Medical History

(Please print the following information)

PATIENT MEDICAL HISTORY

LIST ALL ALLERGIES:_____ NO KNOWN ALLERGIES ____

Y N Lung Disease: Asthma__TB__Other_____ Y N Blood Disorder: Anemia__Bruising/Bleeding___

Y N Kidney Disease-Type:_____ Other_____

Y N Arthritis-Type: Osteo___ Rheumatoid___ Y N G.I. Disorder: Ulcer_____Gallbladder_____

Y N Diabetes: Diet___Insulin___No. of Yrs___ Hepatitis_____ Other_____

Y N Thyroid Disease-Type: Hyper___Hypo___ Y N Seasonal Allergies___ Sinus Problems_____

Y N Neurological Disease_____ Y N High Blood Pressure_____ # of Yrs_____

Y N Headaches or Migraines_____ Y N Stroke_____

Y N Cancer-Type:_____ Y N Seizures, Convulsions, Tremors or Fainting_____

Y N Central Nervous System Disorders_____ Y N Temporal Arteritis_____

Y N Heart Disease_____ Y N Recent Fever?_____

Cardiovascular: Heart Attack_____ Y N (Women) Are You Pregnant or Nursing?_____

Angina_____ Other_____ Y N Recent Change in Weight_____ Appetite_____

Y N Carotid Artery Disease_____ Y N Do You Use Recreational Drugs?_____

Y N Immune System Disorders: Leukemia_____ Y N Do You Smoke? Packs Per Day____Week_____

Lupus___ HIV___AIDS___MRSA_____ Y N Do You Drink ? #Per Day___Week__Month___

Y N Any Other Disease/Disorder/Injury Not Y N Do You Live Alone?_____

Listed_____

LIST ALL MEDICATIONS & VITAMINS YOU ARE CURRENTLY TAKING

_____ _____

_____ _____

LIST ANY EYEDROPS YOU ARE CURRENTLY USING

Name:_____ How Often?_____

Name:_____ How Often?_____

PATIENT PRINTED NAME_____ DOB_____ DATE_____

(Be sure to complete the second page – Your Eye History)

Pasadena EYE CENTER

YOUR EYE HISTORY

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS IN THE PAST?

Y N Cataracts? Y N Corneal Disease? Y N Retinal Disease? Y N Glaucoma? Y N Iritis?

Y N Crossed Eyes? Eye Injury, Which Eye and Injury Date?_____

Y N Any Other Eye Disorders?_____

Cataract Surgery? Y N Date of Surgery: Right Eye_____ Left Eye_____

Other Surgery & Date of Surgery: Right Eye_____ Left Eye_____

Right Eye_____ Left Eye_____

ANY CHANGES IN YOUR DAILY LIVING ACTIVITIES DUE TO VISUAL CHANGES?

Watching TV_____ Seeing Street Signs_____ Night Driving_____ Reading_____ Computer_____

Sewing_____ Tennis_____ Golf_____ Other_____

When Was Your Last Eye Exam?_____ Do You Wear glasses? Y N Contact Lenses? Y N

Who was your Previous Eye Doctor?_____

SURGICAL HISTORY

Date:_____ Type:_____

Date:_____ Type:_____

Date:_____ Type:_____

FAMILY HISTORY: (Note Relation to Patient Using Abbreviations: F=Father M=Mother P=Paternal S=Sister B=Brother GF=Grandfather GM=Grandmother U=Uncle A=Aunt)

Y N Glaucoma_____ Y N Retinal Detachment_____

Y N Cataracts_____ Y N Other Eye Problems_____

Y N Corneal Disease_____ Y N Diabetes_____

Y N Macular Degeneration_____ Y N Heart Conditions_____

Y N Retinitis Pigmentosa_____ Y N Stroke_____

Y N Diabetic Retinopathy_____ Y N Other General Health Problems_____

PATIENT PRINTED NAME_____ DOB_____

PATIENT SIGNATURE_____ DATE_____