ALL CITY OPHTHALMOLOGY SERVICES, P.C.

MEDICAL HISTORY FORM

DATE:_____ D.O.B. _____

_____
PATIENT'S NAME

PLEASE CHECK EACH ITEM YES OR NO AS THEY RELATE TO YOUR HEALTH

	YES	NO		YES	NO		YES	NO
BLOOD-LYMPH			***STOMACH - INTESTINES***			***PSYCHIATRIC***		
ANEMIA			GASTROINTESTINAL PROBLEM			ANXIETY/DEPRESSION		
EASY BRUISING			LIVER PROBLEMS			MOOD SWINGS		
			HEPATITIS B Or C					
MUSCULOSKELETAL						***KIDNEY-BLADDER-URINARY***		
ARTHRITIS			***CARDIOVASCULAR***			PROSTATE		
			MURMUR			URINATION DIFFICULTY		
LUNGS-RESPIRATORY			CHEST PAIN/ANGINA			BLADDER		
EMPHYSEMA			PALPITATIONS			KIDNEY DIALYSIS		
ASTHMA			HEART ATTACK			#TIMES: /WK		
			WHEN?					
ENDOCRINE			HIGH BLOOD PRESSURE			***EAR-NOSE-MOUTH-THROAT***		
DIABETES TYPE I OR TYPE II						HEARING LOSS/PROBLEMS		
HOW LONG?			***NERVOUS SYSTEM***			SINUS		
THYROID			SEIZURES/EPILEPSY					
			NUMBNESS			***SKIN***		
CANCER			STROKE – WHEN?			RASHES		
TYPE:			HEADACHE			SKIN ULCERS		
RADIATION CHEMOTHERAPY						SWELLING		
GENERAL HEALTH						***OTHER DISEASES NOT LISTED??***		
WEIGHT LOSS								
FATIGUE								
FEVER								

ARE YOU ALLERGIC TO ANY MEDICINES? NO YES (PLEASE LIST) _____

WHAT MEDICINES DO YOU TAKE? _____

WHAT EYE MEDICINES DO YOU TAKE? _____

DO YOU TAKE BLOOD THINNERS? NO ____ YES ____ ASPIRIN? _____ COUMADIN? ____ PLAVIX? _____

PLEASE LIST YOUR PAST SURGERIES _____

FAMILY /SOCIAL HISTORY:

[ ] MARRIED [ ] WIDOWED [ ] SINGLE [ ] DIVORCED NUMBER OF CHILDREN ____

[ ] NON-SMOKER [ ] SMOKER # OF PACKS PER DAY ____ [ ] NO ALCOLHOL [ ] ALCOHOL – NUMBER OF DRINKS PER WEEK? ____

WHAT IS YOUR OCCUPATION? _____

CHECK YES OR NO AS RELATED TO YOUR FAMILY HISTORY. EXPLAIN POSITIVE RESPONSES (I.E. MOTHER, FATHER, GRANDMOTHER, ETC.

	YES	NO	FAMILY MEMBER		YES	NO	FAMILY MEMBER
GLAUCOMA				**DIABETES**			
CATARACT				**HYPERTENSION**			
RETINAL				**VASCULAR**			
CARDIAC				**CANCER**			

PATIENT'S SIGNATURE _____ **DATE** _____