MEDICAL HISTORY – KILMORE EYE ASSOCIATES

DATE: _____ **DATE OF BIRTH_____**

PATIENT NAME: _____

PLEASE CHECK ALL THAT APPLIES TO YOU: (HPI – HISTORY PRESENT ILLNESS)

EYES:

___ Glaucoma
___ Cataracts
___ Retinal Detachments
___ Macular Degeneration
___ Floaters
___ Light Flashes
___ Blurred Vision
___ Double Vision
___ Loss of Vision (peripheral/center/horizontal/vertical)
___ Glare/Halo/Light Sensitivity
___ Dryness/Burning/Sandy
___ Blindness
___ Foreign Body Sensation
___ Itching
___ Excess Tearing
___ Eye Pain/Soreness
___ "Lazy Eye"

GENERAL MEDICAL: (ROS- REVIEW OF SYMPTOMS) circle yes or no

yes/no Blood Pressure (high/low)
yes/no Diabetes (diet/medication/insulin) Type 1 or 2
yes/no Heart Disease (Vascular/pacemaker/irregular beat/CHF/heart attack/stents)
yes/no Neurological (Stroke/MS/paralysis/epilepsy/fainting/migraines/convulsions)
yes/no Respiratory (COPD/asthma/bronchitis/shortness of breath/TB/emphysema)
yes/no Cancers
yes/no Gastrointestinal (stomach /ulcers/colitis/liver)
yes/no Kidney/Bladder (dialysis/stones/infection/failure)
yes/no Muscles/Bones/Joints
yes/no Thyroid (hyper/hypo/Graves)
yes/no Psychiatric (anxiety/depression/insomnia)
yes/no Arthritis (rheumatoid/osteoporosis/juvenile)
yes/no Autoimmune Diseases (HIV/AIDS/Hepatitis/Fibromyalgia/Lupus)

FAMILY HISTORY:

___ Glaucoma (father/mother/sibling/aunt/uncle/grandparent)
___ Cataract (father/mother/sibling/aunt/uncle/grandparent)
___ Macular Degeneration (father/mother/sibling/aunt/uncle/grandparent)
___ Retinal Detachment (father/mother/sibling/aunt/uncle/grandparent)
___ Retinitis Pigmentosa (father/mother/sibling/aunt/uncle/grandparent)
___ Blindness (father/mother/sibling/aunt/uncle/grandparent)
___ Arthritis (father/mother/sibling/aunt/uncle/grandparent)
___ Cancer (father/mother/sibling/aunt/uncle/grandparent)
___ Diabetes (father/mother/sibling/aunt/uncle/grandparent)
___ Heart Disease/High Blood Pressure/Stroke(father/mother/sibling/aunt/uncle/grandparent)
___ Kidney Disease (father/mother/sibling/aunt/uncle/grandparent)
___ Autoimmune Diseases (father/mother/sibling/aunt/uncle/grandparent)
___ Thyroid Disease (father/mother/sibling/aunt/uncle/grandparent)

TURN OVER →

SOCIAL HISTORY:

Current Occupation: _____

Education: High School Vocational College

Marital Status: Single Married Divorced Widowed

Do you Drive? Yes No **Do you have visual difficulty driving?** Yes No

Do you have problems with night vision? Yes No

Do you currently wear glasses? Yes No **-If yes, how old is the prescription?** _____

Do you wear contact lenses? Yes No

Do you drink alcohol/or use drugs? Yes No (Social or Daily - Quit)

Do you smoke? Yes No Quit

Blood Transfusion? Yes No

PLEASE LIST ALL YOUR MEDICATIONS -PRESCRIPTIONS/NONPRESCRIPTION

(If you have a CURRENT list with you, we can make a copy and attached it to this sheet)

NAME **DOSAGE** **FREQUENCY** **ORAL / INJECTION / TOPICAL**

***** Technician Date & Sign: Information Reviewed With Patient***** *****Patient: Do Not Write in Boxes*****

*****DATE**									
*****SIGN**									

DO YOU HAVE ANY ALLERGY TO MEDICATIONS: - If so, please list:

PLEASE LIST YOUR PAST SURGERIES: (Cataracts/heart/tonsillectomy/cancers/etc)

DO NOT WRITE BELOW THIS LINE

Physician's Signature: History Reviewed (Date and Initial)

DATE									
SIGN									