PATIENT MEDICAL HISTORY FORM FOR ALBEMARLE EYE CENTER

NAME:_____ SEX:_____ DATE OF BIRTH:_____

DATE:_____ PRIMARY CARE PHYSICIAN: _____

Please fill out the following: If "YES" please explain further and/or give date.

YES	NO	
		CURRENT EYE COMPLAINTS
( )	( )	Loss of Vision
( )	( )	Blurred Vision
( )	( )	Double Vision
( )	( )	Mucous Discharge
( )	( )	Redness
( )	( )	Sandy or gritty feeling
( )	( )	Itching, burning, tearing
( )	( )	Glare Problem
( )	( )	Eye Pain
( )	( )	Floaters
( )	( )	Flashes
( )	( )	Other:_____
		PAST PATIENT MEDICAL HISTORY
( )	( )	Eye Diseases
( )	( )	Diabetes
( )	( )	Thyroid Disease
( )	( )	Heart Disease, Heart Attacks
( )	( )	High Blood Pressure
( )	( )	Other:_____
( )	( )	List any Previous Surgeries
		CURRENT CONDITIONS (ROS)
( )	( )	Diabetes
( )	( )	Thyroid Problems
( )	( )	Anemia
( )	( )	Sinus problems
( )	( )	High Blood Pressure
( )	( )	Heart Disease
( )	( )	Acid Reflux
( )	( )	Shortness of Breath

YES	NO	
( )	( )	Asthma
( )	( )	Emphysema
( )	( )	Positive TB Test
( )	( )	Ulcer
( )	( )	Hepatitis
( )	( )	Kidney/Bladder Problems
( )	( )	HIV/Aids
( )	( )	Arthritis
( )	( )	Migraine Headaches
( )	( )	Headaches
( )	( )	Cancer/Type:_____
( )	( )	Nervous Disorders
( )	( )	Seasonal Allergies
( )	( )	Sickle Cell
( )	( )	Cholesterol_____
( )	( )	Other:_____
		FAMILY HISTORY
( )	( )	Eye problems, Explain_____
( )	( )	Diabetes
( )	( )	Heart Problems
( )	( )	Glaucoma
( )	( )	Other:_____
		SOCIAL HISTORY
( )	( )	Do You Smoke?
( )	( )	Do You Drink Alcohol?
( )	( )	Do You Drive?

LIST MEDICATIONS YOU ARE CURRENTLY TAKING

LIST MEDICATIONS YOU ARE ALLERGIC TO

(Dr. Observation) M.S. _____