Fox Cities Eye Clinic

Initial Patient Medical History

Male ☐ **Female** ☐

Patient's Eye History:

Do you have or have you ever had any of the following:

	Yes	No
Cataracts	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Diabetic Retinopathy	☐	☐
Lazy Eye	☐	☐
Optic Nerve Conditions	☐	☐
Eye Injury	☐	☐

	Yes	No
Cataract Surgery	☐	☐

If yes:
When?______________________________
Which Eyes: Right Left Both
Surgeon/Location____________________

	Yes	No
Glaucoma Surgery	☐	☐

If yes:
When?______________________________
Which Eyes: Right Left Both
Surgeon/Location____________________

	Yes	No
Retinal Surgery	☐	☐

If yes:
When?______________________________
Which Eyes: Right Left Both
Surgeon/Location____________________

Please List All Prescribed and Over the Counter **Eye Medications:**

Name of Eye Medications **Dosage**

1.__________________________________
2.__________________________________
3.__________________________________
4.__________________________________
5.__________________________________

Family Eye History:

Does anyone in your immediate family have any of the following (**Blood Relative):**

	Yes	No	Relative
Cataracts	☐	☐	__________
Glaucoma	☐	☐	__________
Macular Degen	☐	☐	__________
Diabetic Retin	☐	☐	__________
Retinal Detach	☐	☐	__________
Lazy Eye	☐	☐	__________
Blindness	☐	☐	__________

Other Ocular Conditions
Please Explain____________________

Preferred Name and Location of Pharmacy:

____
Name **Location**

Please List All Prescribed and Over the Counter
SystemicMedications:

Name of Medication **Dosage**

1.__________________________________
2.__________________________________
3.__________________________________
4.__________________________________
5.__________________________________
6.__________________________________
7.__________________________________
8.__________________________________
9.__________________________________
10.__________________________________
11.__________________________________
12.__________________________________
13.__________________________________

Fox Cities Eye Clinic
Patient Medical History Form

Name:______________________________DOB:___________Date:__________

Male ☐ Female ☐

Constitutional:

	Yes	No
Fatigue	☐	☐
Fever	☐	☐
Night Sweats	☐	☐
Weight Gain or Loss	☐	☐

Other________________________

HEENT:

	Yes	No
Hearing Loss	☐	☐
Sinus Problems	☐	☐

Other________________________

Respiratory:

	Yes	No
Asthma	☐	☐
Shortness of Breath	☐	☐
COPD/Emphysema	☐	☐

Other________________________

Cardiovascular:

	Yes	No
Chest Pressure or Discomfort	☐	☐
Irregular Heartbeat/Palpitations	☐	☐
Heart Failure	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐

Other________________________

Gastrointestinal:

	Yes	No
Abdominal Pain	☐	☐
Irritable Bowel	☐	☐
Crohn's Disease	☐	☐

Other________________________

Genitourinary:

	Yes	No
Kidney/Bladder	☐	☐

Other________________________

Metabolic Endocrine:

Diabetes:	Yes	No
Insulin Therapy	☐	☐
Oral Medication/Diet Control	☐	☐
Blood Sugar Controlled	☐	☐

Other________________________

Neurological:

	Yes	No
Dizziness	☐	☐
Headache	☐	☐

Other________________________

Psychiatric:

	Yes	No
Depressed Mood	☐	☐
Emotional Changes	☐	☐
Nervousness	☐	☐

Other____________________

Skin:

	Yes	No
Rash	☐	☐
Skin Lesion	☐	☐

Other____________________

Musculoskeletal:

	Yes	No
Arthralgias/Arthritis	☐	☐
Joint Swelling	☐	☐
Lupus	☐	☐

Other____________________

Hematologic Lymphatic:

	Yes	No
Bleeding	☐	☐
Bruising	☐	☐

Other____________________

Immunologic:

	Yes	No
Enviromental Allergies	☐	☐
Food Allergies	☐	☐
Seasonal Allergies	☐	☐
Medication Allergies	☐	☐

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Do You Presently Have Any Problems in the Following Areas?

	Yes	No
Loss or Blurred Vision	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Itching, burning or discharge	☐	☐
Redness	☐	☐
Gritty Feeling, dryness, tearing	☐	☐
Glare/light sensitive or halos	☐	☐
Eye pain or soreness	☐	☐
Infection of eye, lashes or lids	☐	☐
Lid swelling or bumps	☐	☐