MEDICAL HISTORY

DATE: ____________________

NAME: ____ **DATE OF BIRTH:** _____________ **AGE:** __________

EMAIL ADDRESS: ____

Do you have any allergies to any medications? YES NO If yes, please list here: ______________________________________

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.)

____

____

List any OCULAR surgeries & DATES/OCULAR medications:

____

____

____

List any surgeries you have had (tonsillectomy, appendectomy):

____

____

____

List any medications you are currently taking:

Have you had the Influenza (flu) vaccine? ☐ No Reason for not taking: ____________________________

☐ Yes Date: ____________________________

Have you had the Pneumonia vaccine? ☐ No ☐ Yes Date: ____________________________

Are you currently taking blood thinners (aspirin, Plavix, Coumadin, Pradzxa? YES NO

Do you take Amiodarone, Cordarone, Pacerone, Ethambutol, Viagra, Cialis, Levetra, Reglen? YES NO

Do you have a cardiac pacemaker or any metal implants or shunts? YES NO

Are you pregnant or breastfeeding, or is there a possibility you may be pregnant? YES NO

Do you wear contact lenses? YES NO

Date of your last eye exam: ____

If yes, how long have you had your current prescription? ____

Do you **currently** have any problems in the following areas? If YES, please provide information.

	YES	NO	DETAILS
Loss of vision or blurred vision			
Fluctuating vision			
Distorted vision (halos), glare, or light sensitivity			
Loss of side vision			
Mucous discharge, redness, tearing, or burning			
Sandy or gritty feeling, itching or burning			
Eye pain or soreness			
Infection of eye or lid			
Crossed Eyes, lazy eye, or double vision			
Drooping eyelid			

	YES	NO	DETAILS
General/Constitutional (Fever, weight loss, etc.)			
Ears, Nose, Throat (stuffy nose, earache, cough, etc.)			
Cardiovascular (high blood pressure, racing pulse, etc.)			
Respiratory (congestion, wheezing, etc.)			
Gastrointestinal (upset stomach, diarrhea, etc.)			
Muscles, Bones, Joints (pain, stiffness, swelling, etc.)			
Skin (pimples, warts, growths, rash, etc.)			
Neurological (numbness, headache, seizures, dizziness, limb weakness, imbalance, fatigue, etc.)			
Psychiatric (anxiety, depression, insomnia, etc.)			
Endocrine (diabetes, hypothyroid, etc.)			
Blood/Lymph (cholesterolemia, anemia, etc.)			
Allergic/Immunologic (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY	M = MOTHER	F = FATHER	S = SIBLING; GP = GRANDPARENT
DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

Current Occupation: ______________________________

Education (high school, vocational school, college degree): ______________________________

Marital Status (married, divorced, single, widowed): ______________________________

Living Arrangements: ______________________________

Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you have problems with night vision? YES NO

Do you drink alcohol? YES NO

If yes: occasional 1/day 2-3/day 4+/day

Do you use tobacco or pipe? YES NO

If yes: heavy or light

Have you ever tried to wear contact lenses? YES NO

Do you currently wear glasses? YES NO

Have you ever had a blood transfusion? YES NO

Do you smoke cigarettes or cigars? YES NO

If yes: 1/2 pack/day 1 pack/day 1+pack/day

Tech/Updated: ____________ ____________ ____________ ____________

Physician's Signature: ______________________________

UAB CALLAHAN EYE