



MEDICAL HISTORY FORM

Name: _____

Date: _____

Sex: M/F Family Physician: _____

Birth Date: _____

PAST MEDICAL HISTORY

List ALL prescription medications you take along with dosage and times per day:

List ALL Herbal Supplements you now take:

List ALL Major Illnesses and Injuries:

List ALL Surgeries you have had. Please indicate the date and/or year behind surgery:

Have you ever had any problems with anesthesia? No Yes Reaction: _____

Have you ever had MRSA, VRE, or any serious drug resistant infection? No Yes

Are you ALLERGIC TO ANY MEDICATIONS? No Yes

List the medication and reaction:

Are you ALLERGIC TO SHELLFISH? No Yes

Are you ALLERGIC TO IVP Dye? No Yes

Are you ALLERGIC TO IODINE? No Yes

OTHER ALLERGIES? List the allergy and reaction.

Are you Sensitive/ Allergic to Rubber or Latex Products? No Yes Reaction: _____

Name: _____

Birth Date: _____

SOCIAL HISTORY

Current or Past Occupation: _____

Do you drive? No Yes Do you smoke? No Yes If yes, number of packs/day: _____

Do you drink alcohol? No Yes If yes, number of drinks/week: _____

Have you ever had a blood transfusion? No Yes If yes, please give date: _____

Have you ever been in intimate contact with a person who had a sexually transmitted disease? No Yes

Have you ever or do you currently use street drugs? No Yes

FAMILY HISTORY

Relationship

Disease

Blindness	<input type="radio"/> No	<input type="radio"/> Yes	_____
Cataracts	<input type="radio"/> No	<input type="radio"/> Yes	_____
Glaucoma	<input type="radio"/> No	<input type="radio"/> Yes	_____
Macular Degeneration	<input type="radio"/> No	<input type="radio"/> Yes	_____
Retinal Detachment	<input type="radio"/> No	<input type="radio"/> Yes	_____
Corneal Dystrophy	<input type="radio"/> No	<input type="radio"/> Yes	_____
Arthritis	<input type="radio"/> No	<input type="radio"/> Yes	_____
Cancer	<input type="radio"/> No	<input type="radio"/> Yes	_____
Diabetes	<input type="radio"/> No	<input type="radio"/> Yes	_____
Heart Attacks	<input type="radio"/> No	<input type="radio"/> Yes	_____
High Blood Pressure	<input type="radio"/> No	<input type="radio"/> Yes	_____
Stroke	<input type="radio"/> No	<input type="radio"/> Yes	_____
Thyroid Disease	<input type="radio"/> No	<input type="radio"/> Yes	_____
Other	<input type="radio"/> No	<input type="radio"/> Yes	_____

REVIEW OF SYSTEMS

Do you have any problems in the following areas? Please check NO or YES. **If YES, provide information.**

Constitutional Systems

Do you have a Cold/Fever?	<input type="radio"/> No	<input type="radio"/> Yes	_____
Weight loss in the past 4 months without dieting	<input type="radio"/> No	<input type="radio"/> Yes	_____

Eyes

Loss of Side Vision	<input type="radio"/> No	<input type="radio"/> Yes	_____
Double Vision	<input type="radio"/> No	<input type="radio"/> Yes	_____
Redness	<input type="radio"/> No	<input type="radio"/> Yes	_____
Burning	<input type="radio"/> No	<input type="radio"/> Yes	_____
Foreign Body Sensation	<input type="radio"/> No	<input type="radio"/> Yes	_____
Excess tearing/watering	<input type="radio"/> No	<input type="radio"/> Yes	_____
Glare/Light Sensitivity	<input type="radio"/> No	<input type="radio"/> Yes	_____
Eye pain/soreness	<input type="radio"/> No	<input type="radio"/> Yes	_____
Chronic infection of eye or eyelid	<input type="radio"/> No	<input type="radio"/> Yes	_____

Ears, Nose, Mouth, Throat

Sinus Congestion	<input type="radio"/> No	<input type="radio"/> Yes	_____
Dry throat/mouth	<input type="radio"/> No	<input type="radio"/> Yes	_____
Chipped or loose teeth, dentures, caps, bridgework, braces?	<input type="radio"/> No	<input type="radio"/> Yes	_____

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Respiratory (Lungs/Breathing)

- Asthma, Pneumonia, or Tuberculosis No Yes _____
- Wheezing No Yes _____
- COPD No Yes _____
- Abnormal chest x-ray No Yes _____
- Do you have a cough? No Yes _____
- Do you bring anything up when you cough? No Yes _____
- Difficulties breathing No Yes _____
- Shortness of breath No Yes _____
- Do you use a CPAP? No Yes _____
- Do you wake up short of breath during the night? No Yes _____
- Can you walk up two flights of stairs without getting short of breath? No Yes _____
- Do you have sleep apnea? No Yes _____
- Have you been told you snore loudly or have periods when you stop breathing in your sleep? No Yes _____

Cardiovascular

- Angina/chest pain No Yes _____
- Heart murmur No Yes _____
- Heart attack No Yes _____
- High blood pressure No Yes _____
- High cholesterol No Yes _____
- Pacemaker/ICD No Yes _____
- Congestive heart failure No Yes _____
- Mitral valve prolapse No Yes _____
- Irregular heartbeat No Yes _____
- Do you take any blood thinners? No Yes _____
- Have you had open heart surgery? No Yes _____

Gastrointestinal (Stomach/intestines/liver)

- Heartburn or Reflux/GERD No Yes _____
- Peptic Ulcer Disease No Yes _____
- Hiatal Hernia No Yes _____
- Colitis No Yes _____
- Irritable Bowel Syndrome No Yes _____
- Diverticulitis No Yes _____
- Crohn's Disease No Yes _____
- Colon Cancer No Yes _____
- Jaundice No Yes _____
- Hepatitis No Yes _____

Genitourinary (Genitals/Kidney/Bladder)

- If female, date of last menstrual period? _____
- Could you be pregnant? No Yes _____
- Kidney problems No Yes _____
- Renal disease No Yes _____
- Bladder problems No Yes _____
- Are you on Dialysis? No Yes _____

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Musculoskeletal

- Any physical disabilities? No Yes _____
- Numbness or weakness in an arm or leg? No Yes _____
- Back Problems No Yes _____
- Can you lie flat on your back in bed? No Yes _____

Integumentary

- Skin problems No Yes _____
- Do you bruise easily? No Yes _____
- Do you have any open/drainage/red wounds? No Yes _____

Neurological

- Stroke No Yes _____
- Severe headaches or migraines No Yes _____
- Any history of head injury? No Yes _____
- Any episodes of epilepsy, seizures, falling out? No Yes _____

Endocrine (Diabetes/Thyroid)

- Do you have diabetes? No Yes _____
- Thyroid problems? No Yes _____

Hematologic- Lymphatic

- Any bleeding tendencies? No Yes _____
- Any history of blood clots? No Yes _____
- Have you ever been anemic? No Yes _____

Allergy/Immunology

- Seasonal allergies No Yes _____
- Hay fever symptoms? No Yes _____

Psychiatric

- Have you ever been under the care of a Psychiatrist? No Yes _____
- Anxiety/Depression No Yes _____
- Do you feel safe in your home? No Yes _____

Patient Signature: _____

Date: _____

Patient Name (Printed): _____

Eyes of York Physician Signature: _____

Date: _____

I attest that I have personally reviewed the above health survey and noted further information where appropriate.