

# Patient Medical History Record

Today's Date: \_\_\_\_\_

**In an effort to better serve our patients and to assist the doctor with your examination, we ask that you complete this survey as accurately as possible. Please answer all questions. Thank you.**

Name:	Medical Doctor:
Date of Birth:	Last Seen:
<b>Allergies:</b>	<b>Medications:</b>
<i>Please list all known allergies:</i>	<i>Please list all medications:</i>

<b>Symptoms:</b>	
<i>Do you <u>currently</u> have any of the following problems?</i>	<i>If yes, please explain:</i>
Heart Problems (Chest pain, irregular heartbeat, etc.)	No Yes _____
Respiratory Problems (shortness of breath, wheezing, cough)	No Yes _____
Skin (rashes, excessive dryness, rosacea)	No Yes _____
Musculoskeletal Problems (muscle aches, joint pain, swollen joints)	No Yes _____
Neurological Problems (headaches, numbness, weakness, paralysis)	No Yes _____
Psychiatric Problems (depression, anxiety)	No Yes _____
Chronic Fever, unexpected weight loss/gain, fatigue	No Yes _____
Ear/nose/throat Problems (hearing loss, sinus problems, sore throat)	No Yes _____
Endocrine Problems (diabetes, thyroid problems)	No Yes _____

<b>Family Medical History:</b>			
<i>Have you or an immediate family member (parent, grandparent, sibling) ever had any of the following conditions?</i>			
Self/Family	Self/Family	Self/Family	Self/Family
Cataract _____	Blindness _____	Asthma _____	Arthritis _____
Glaucoma _____	High Blood Pressure _____	Chronic Bronchitis _____	Thyroid Disease _____
Eye Injury _____	Heart Disease _____	Sinus Problems _____	Liver Disease _____
Crossed/Lazy Eye _____	Stroke _____	Tuberculosis _____	Cancer _____
Retinal Detachment _____	Diabetes _____	HIV/AIDS _____	Dry Eye Syndrome _____
Retinal Degeneration _____	Anemia _____	Migraines _____	Other _____
Macular Degeneration _____	Bleeding Problems _____	Seizures/Epilepsy _____	Other _____

<b>Surgeries/Other:</b>			
<i>Please list any previous surgeries, including eye surgeries and laser procedures:</i>		Sports Played Currently:	
Surgery	Date	Surgery	Date
		Current Hobbies:	

Smoker / NonSmoker?      Social Drinker? No Yes      Do you use recreation drugs? No Yes

<b>For Student Patients:</b>	
<i>Struggles in school can many times be related to a vision problem such as tracking or eye-teaming. Please answer the following questions regarding your student. Thank you.</i>	
Does student like to read for enjoyment?	No Yes
Has student ever been diagnosed with learning disability?	No Yes
Has student ever been diagnosed with ADD/ADHD?	No Yes
Do you feel that the student has a learning disability/dyslexia?	No Yes
Has the student had difficulty learning how to read?	No Yes
Has the student had difficulty with spelling?	No Yes
Has the student received remedial help from school?	No Yes

Patient or Guardian Signature \_\_\_\_\_  
 PatMedHist.xl.08/28/08