



Laura L. Harris, M.D., F.A.C.S

**PATIENT MEDICAL HISTORY**

Name		Nickname		Date
Date of Birth	Age	Phone	Referring Doctor	
<b>Past Eye Disease/Injuries:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:				
<b>Other surgeries:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:				
<b>Eye Medications:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:				
<b>Allergies to Food, Medications or Latex:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:				

Please answer the following questions about your medical status and history.

Have you ever been treated for any of the following medical conditions? Please check yes or no and circle all that apply. Explain further in the space provided if necessary.

- Yes  No Arthritis (Rheumatoid, Osteo–degenerative) \_\_\_\_\_
- Yes  No Blood Disease (Anemia, Leukemia, Clotting problems) \_\_\_\_\_
- Yes  No Ear, Nose, Throat (Hearing Loss, Sinus Disease) \_\_\_\_\_
- Yes  No Diabetes (Type, how controlled and when diagnosed) \_\_\_\_\_
- Yes  No Thyroid Disease (Hypo, Hyper, Graves disease) \_\_\_\_\_
- Yes  No Lung Disease (Asthma, Emphysema, COPD, Chronic Bronchitis) \_\_\_\_\_
- Yes  No Heart Disease (Heart Attack, Angina, Arrhythmia, Heart Failure, Heart Valve Disease, Bypass Surgery) \_\_\_\_\_
- Yes  No High Blood Pressure \_\_\_\_\_
- Yes  No Gastrointestinal Disease (Ulcers, Esophageal Reflux, Intestinal or Liver Disease) \_\_\_\_\_
- Yes  No Genitourinary Disease (Kidney Disease, Dialysis, Kidney Stones) \_\_\_\_\_
- Yes  No Neurological Problems (Stroke, Mini Strokes, Seizures, Paralysis) \_\_\_\_\_
- Yes  No Skin Disease (Eczema, Psoriasis, Acne, Rosacea) \_\_\_\_\_
- Yes  No Mental Health (Depression, Anxiety, Schizophrenia, Bipolar) \_\_\_\_\_
- Yes  No Cancer (List Type or Location and Date) \_\_\_\_\_
- Yes  No Infectious Disease (TB, Syphilis, Gonorrhea, AIDS, HIV, Hepatitis, MRSA) \_\_\_\_\_
- Other Problems \_\_\_\_\_

**Review of Systems: Do you currently have any of the following problems? Check all that apply.**

- Yes  No **Fever or Weight Loss/Fatigue**
- Yes  No **Ear/Nose/Throat (Hearing Loss/Sinus)**
- Yes  No **Cardiovascular (Chest Pain, Irregular Heartbeat)**
- Yes  No **Respiratory (Shortness of Breath, Wheezing)**
- Yes  No **Urinary Problems (Pain or Discomfort, Blood)**
- Yes  No **Skin Problems (Rashes, Excessive Dryness)**
- Yes  No **Musculoskeletal (Muscle Aches, Arthritis)**
- Yes  No **Neurological (Numbness, Weakness, Headaches)**
- Yes  No **Hematologic (Bleeding Tendencies, Anemia)**
- Yes  No **Gastrointestinal (Heartburn, Abdominal Pain, Diarrhea)**
- Yes  No **Allergic/Immunologic (Seasonal Allergies, Hay Fever)**
- Yes  No **Psychiatric Problems (Depression, Anxiety)**

**Eye Disease:**

**Have you ever had any eye disease? If yes, please explain and include the year diagnosed.**

- Yes  No **Cataract** \_\_\_\_\_
- Yes  No **Corneal Disease or Transplant** \_\_\_\_\_
- Yes  No **Diabetic Eye Disease** \_\_\_\_\_
- Yes  No **Glaucoma** \_\_\_\_\_
- Yes  No **Lazy Eye (Amblyopia)** \_\_\_\_\_
- Yes  No **Macular Degeneration** \_\_\_\_\_
- Yes  No **Muscle Disorder (Crossed Eye)** \_\_\_\_\_
- Yes  No **Retinal Detachment or Hole** \_\_\_\_\_
- Yes  No **Injury** \_\_\_\_\_
- Yes  No **Surgery or Laser** \_\_\_\_\_

**Family History of Disease:**

**Do you have a family history of any of the following diseases? Relative affected. (Ex., mother, father, sister, brother)**

- Yes  No **Diabetes** \_\_\_\_\_
- Yes  No **Glaucoma** \_\_\_\_\_
- Yes  No **Retinal Disease** \_\_\_\_\_

**Social History:**

- Yes  No **Do you use tobacco products? If so, what type?** \_\_\_\_\_
- Yes  No **Do you consume alcohol?**
- Yes  No **Do you work? (How many hours?)** \_\_\_\_\_

<b>Patient Signature:</b>	<b>Date:</b>
<b>Physician Signature:</b>	<b>Date:</b>