Campus Eye Center
PATIENT OPHTHALMIC / MEDICAL HISTORY

Name: _____ DOB: _____ Date: _____

Primary Dr. _____ Referring Dr. _____

Ocular History

Yes No

□ □ Cataracts_____
Surgery □ W/IOL □ W/O IOL
Date of surgery: R. Eye:_____
L. Eye:_____

□ □ Retinal Disease _____

□ □ Crossed Eyes _____

□ □ Iritis _____

□ □ Corneal Disease _____

□ □ Glaucoma _____

□ □ Injury _____

□ □ Others _____

Social History

Yes No

□ □ Do you have a history of tobacco use?
□ Former □ Current

□ □ Do you drink alcohol? _____
□ Social □ Daily

□ □ Do you take recreational drugs? _____

Are you working? □ _____ Retired? □ _____

Occupation _____

Family / Relative History

(Note Relation to patient: F-Father, M-Mother, P-Paternal, M-Maternal, S-Sister, B-Brother, GF-Grandfather, GM-Grandmother, U-Uncle, and A-Aunt)

Yes No

□ □ Cataracts _____

□ □ Glaucoma _____

□ □ Diabetes _____

□ □ Retinal Detachment _____

□ □ Macular Degeneration _____

□ □ Strabismus _____

□ □ Amblyopia _____

□ □ Heart _____

□ □ Cancer _____

□ □ Stroke _____

Other: _____

□ No Known Drug Allergies

□ Allergies / Reaction:

_____

_____

Medications (Including EYEDROPS)

Name of Medication	Dosage	Instructions for Medication

All Prior Surgeries

_____

_____

_____

(Over)

Review of Systems: (Do you currently have any problems in the following areas?)

Constitutional
- ☐ Sudden weight gain
- ☐ Sudden weight loss
- ☐ Weakness
- ☐ Fever
- ☐ Fatigue
- ☐ Chills
- ☐ Other _____
- ☐ None

Cardiovascular
- ☐ Chest pain
- ☐ Heart disease
- ☐ Bypass surgery
- ☐ Congestive heart failure
- ☐ High cholesterol
- ☐ Hypertension controlled
- ☐ Hypertension uncontrolled
- ☐ Stroke
- ☐ Pacemaker
- ☐ Irregular heart beat
- ☐ Stent
- ☐ Other _____
- ☐ none

Ear, Nose, Throat
- ☐ Hearing aid
  - ☐ Right ear
  - ☐ Left ear
- ☐ Mouth sores
- ☐ Vertigo
- ☐ Chronic sinusitis
- ☐ Sore throat
- ☐ Other _____
- ☐ None

Respiratory
- ☐ COPD
- ☐ Emphysema
- ☐ Lung cancer
- ☐ Pneumonia
- ☐ Sleep apnea
- ☐ Tuberculosis
- ☐ Other _____
- ☐ None

Gastrointestinal
- ☐ GERD (reflux)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hernia
- ☐ Pancreatitis
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Gall bladder disease
- ☐ Other _____
- ☐ None

Genitourinary (kidney/Bladder)
- ☐ Benign prostate hyperplasia
- ☐ Bladder infection
- ☐ Dialysis
- ☐ Kidney failure /stones/transplant
- ☐ Menopause symptoms
- ☐ Ovarian cysts/cancer
- ☐ Prostate cancer
- ☐ Renal cancer
- ☐ Other _____
- ☐ None

Musculoskeletal
- ☐ Arthritis
- ☐ Cerebral palsy
- ☐ Gout
- ☐ Juvenile rheumatoid arthritis
- ☐ MS
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Other _____
- ☐ None

Integumentary (skin)
- ☐ Bruising
- ☐ Changes in nails/hair
- ☐ Dermatitis
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Other_____
- ☐ None

Neurologic
- ☐ Bell's palsy
- ☐ Cranial nerve palsy
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke
- ☐ TIA
- ☐ Epilepsy
- ☐ Migraines
- ☐ Neuropathy
- ☐ Weakness/tingling/numbness
- ☐ Other _____
- ☐ None

Endocrine
- ☐ Diabetes
  - ☐ Type 1
  - ☐ Type 2
  - ☐ Diet controlled diabetes
- ☐ Insulin dependent diabetes mellitus
- ☐ Non-insulin dependent diabetes mellitus
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other _____
- ☐ None

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Blood disorders
- ☐ Enlarged/swollen lymph nodes
- ☐ Leukemia
- ☐ Lyme disease
- ☐ Lymphoma
- ☐ Platelet disorders
- ☐ Other _____
- ☐ None

Allergy/Immu.
- ☐ Allergy shots
- ☐ HIV
- ☐ Lupus
- ☐ Immune disorder
- ☐ Seasonal allergies
- ☐ Other _____
- ☐ None