

# COASTAL EYE CENTER COMPLETE MEDICAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Local Physician \_\_\_\_\_

Endocrinologist \_\_\_\_\_ Rheumatologist \_\_\_\_\_ Cardiologist \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

**DO YOU WEAR GLASSES FOR:** Distance Y N Reading Y N Bifocals Y N Trifocals Y N Progressives Y N

**CURRENT CONTACT LENSES** Y N Past Contact Lenses Y N Distance – Monovision – Bifocal (circle one)

**PLEASE CIRCLE ANY PROBLEMS YOU CURRENTLY HAVE:**

Blurred Vision Halos/Glare Double Vision Dryness/Burning Mucous Discharge Itching  
Excess Tearing/Watering Eye Pain Crossed Eyes/ Lazy Eyes Drooping Eyelid(s)

**EYE HISTORY** – Have you or any of your blood related family members had any of the following?

	<u>SELF</u>	<u>FAMILY MEMBER</u>	<u>RELATION</u>
Cataracts	Y N	Y N	_____
Glaucoma	Y N	Y N	_____
Diabetes	Y N	Y N	_____
Retinal Detachment	Y N	Y N	_____
Macular Degeneration	Y N	Y N	_____
Eye Surgery	Y N	Y N	_____
Refractive Sx	Y N		_____

**SOCIAL HISTORY**

Current or Previous Occupation \_\_\_\_\_

Do you smoke? Y N Past Smoker Y N Amount and duration \_\_\_\_\_

Do you drink alcohol? Y N If yes, list amount per week \_\_\_\_\_

Do you live alone? Y N Do you live in a nursing home? Y N If yes, which one? \_\_\_\_\_

Are you currently in rehab? Y N Are you currently enrolled in hospice? Y N

**MEDICATIONS** - prescription and non-prescription (or attach list)

<u>Drug name</u>	<u>Dose</u>	<u>Drug name</u>	<u>Dose</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ALLERGIES:**

**LIST ANY SURGERIES INCLUDING BUT NOT LIMITED TO EYE SURGERIES, HOSPITALIZATIONS, AND SERIOUS ILLNESSES:**

**FAMILY HISTORY** – mother, father, grandparent or sibling – list serious medical diseases affecting your family members:

**\*PLEASE TURN OVER AND COMPLETE OTHER SIDE!**

**PAST MEDICAL HISTORY** – Please indicate whether you have had any of the following medical problems.

**CHEST LUNGS**

Asthma/Wheezing            Y   N  
Emphysema                    Y   N  
Shortness of Breath        Y   N  
COPD                            Y   N  
Other \_\_\_\_\_

**EXTREMETIES**

Rheumatoid Arthritis      Y   N  
Osteoarthritis                Y   N  
  
Osteoporosis                 Y   N

**GENITOURINARY**

Kidney Stones                Y   N  
Prostate Enlargement      Y   N  
Other \_\_\_\_\_

**Weight Loss**                Y   N

Explain \_\_\_\_\_

**HEART/CARDIOVASCULAR**

Angina Syndrome            Y   N  
Heart Attack                  Y   N  
  
Carotid Disease                Y   N  
Congestive Heart Failure    Y   N  
Cardiac Arrhythmia         Y   N  
Circulation Problems        Y   N  
High Blood Pressure         Y   N  
Pacemaker/Defibrillator    Y   N

**ENDOCRINE**

Diabetes                        Y   N  
Thyroid Disease                Y   N  
Hyper/Hypo (circle one)  
Graves/MG (circle one)  
Other \_\_\_\_\_

**CANCER**

Type \_\_\_\_\_

**NEUROLOGICAL**

Previous Stroke or TIA      Y   N  
Headache                      Y   N  
MS                                Y   N  
Seizures                        Y   N  
Bell's Palsy                    Y   N  
Dementia/Alzheimer's        Y   N  
Parkinson's                    Y   N

**PSYCHIATRIC**

Anxiety                         Y   N  
Depression                     Y   N

**COCHLEAR IMPLANTS**      Y   N

**HEMATOLOGIC**

Bleeding Disorder            Y   N  
High Cholesterol              Y   N  
Blood Transfusion            Y   N

**GASTROINTESTINAL**

Hepatitis                        Y   N  
Ulcers                            Y   N  
GERD/Acid Reflux             Y   N  
Other \_\_\_\_\_

**IMMUNOLOGIC**

Immune Deficiency          Y   N  
Sjogren's                        Y   N  
HIV/AIDS                        Y   N  
Other \_\_\_\_\_

**SKIN**

Shingles                        Y   N  
Melanoma                        Y   N  
Rosacea                         Y   N  
Herpes Simplex                Y   N  
Cancer                            Y   N    Type \_\_\_\_\_

Date \_\_\_\_\_

Doctor Signature \_\_\_\_\_