EYE CENTER OF CENTRAL GEORGIA
MEDICAL HISTORY SHEET

EYE HISTORY:

Have you ever had or been told you have any of the following conditions? Please check all that apply.

□ Glaucoma □ Cataracts □ Strabismus (Crossed eye)
□ Retinal disease □ Wear glasses/contacts □ Amblyopia (Lazy eye)
□ Headaches □ Double vision □ Tearing/mattering
□ Other (please describe): _____

Please list any eye surgeries: _____
If available, please bring records from any eye surgeries.
Please describe any eye injuries: _____

MEDICAL HISTORY:

Have you ever had any problems with the following? Please check all that apply.

Constitution
□ Chronic Fatigue
□ Insomnia
□ Sudden Weight Loss

Cardiovascular
□ Angina
□ Atrial Fibrilation
□ Bypass Surgery
□ Congestive Heart Failure
□ Heart Attack
□ High Cholesterol
□ High Blood Pressure
□ Mitral Valve Prolapse
□ Pacemaker
□ Stent

Respiratory
□ Asthma
□ COPD
□ Emphysema
□ Lung Cancer
□ Sleep Apnea
□ Tuberculosis

Gastrointestinal
□ Cranial Nerve Palsy
□ Crohns' Disease
□ Colitis
□ Constipation
□ Diverticulitis
□ Gall Bladder Disease
□ GERD (Acid Reflux)
□ IBS
□ Ulcers

Genitourinary
□ Dialysis
□ Endometriosis
□ Incontinence
□ Kidney Failure
□ Recurrent UTIs

Musculoskeletal
□ Arthritis
□ Cerebral Palsy
□ Fibromyalgia
□ Gout
□ Hip Replacement
□ Juvenile Rheumatoid Arthritis
□ Marfan's Syndrome
□ Multiple Sclerosis
□ Rheumatoid Arthritis

Integumentary
□ Basal Cell Carcinoma
□ Dermatitis
□ Rosacea
□ Shingles
□ Skin Cancer

Neurological
□ Alzheimer's
□ Bell's Palsy
□ Epilepsy
□ Headaches
□ Migraines
□ Parkinson's
□ Stroke
□ Vertigo

Endocrine
□ Diabetes Type I
□ Diabetes Type II
□ Hyperthyroidism
□ Hypoglycemia
□ Hypothyroidism

Hematologic
□ Anemia
□ Hemophilia
□ Hepatitis
□ Leukemia
□ Lyme Disease
□ Lymphoma

Ears, Nose, Throat
□ Chronic Sinusitis
□ Dentures
□ Ear Infections
□ Hearing Aid
□ Hearing Loss

Allergic/Immunologic
□ Allergy shots
□ HIV/Aids
□ Lupus
□ Seasonal Allergies
□ Sjogren's

Psychiatric
□ Anxiety
□ Bipolar
□ Depression

Any other medical problems? Please explain below.

_____

_____

NAME:_____ **PRIMARY CARE PHYSICIAN:** _____
DATE: _____ **REFERRING PHYSICIAN:** _____

MEDICATIONS:

Please list all the medications which you take, including name, dosage, and frequency.

Name (i.e. Aspirin)	Dose (i.e. 81 mg)	Frequency (i.e. once a day)

Please list any drug allergies you have.

_____

_____

Are you allergic to latex?

□ YES □ NO

SOCIAL HISTORY:

Do you have an advance directive/living will? ☐YES ☐NO

Have you ever used tobacco products? ☐YES ☐NO If yes, how much? _____

Do you ever drink alcoholic beverages? ☐YES ☐NO If yes, how much? _____

What is your current occupation? _____

FAMILY HISTORY:

Has anyone in your family had the following conditions? Please check all that apply and list the relationship.

□ Glaucoma _____
□ Cataracts _____
□ Macular Degeneration _____
□ Retinal Disease _____
□ Blindness/Low Vision _____
□ Strabismus (crossed eye) _____
□ Amblyopia (lazy eye) _____
□ Diabetes _____
□ High Blood Pressure _____
□ Heart Disease _____
□ Cancer _____
□ Kidney Disease _____
□ Thyroid Disease _____
□ Other _____

IF THE PATIENT IS A CHILD AGE 16 OR YOUNGER:

Has the child ever had an eye exam? □ YES □ NO

If yes, where and when? _____

If yes, was he/she given a prescription for glasses? □ YES □ NO

Has the child ever used any eye drops or ointment? □ YES □ NO

If yes, please explain. _____

Has anyone ever noticed any eye turning, squinting, or any other eye concerns? □ YES □ NO

If yes, please explain. _____

Does the child's mother or father wear glasses? □ YES □ NO

If yes, are the glasses for: □ nearsightedness □ farsightedness □ astigmatism

Birth History: □ C-section □ Premature, born at _____ weeks

□ Jaundice □ Oxygen

Birth weight _____lb _____oz