Cornerstone Eye Associates

www.cornerstoneeye.com

***PATIENTS COMPLETE BOTH SIDES***

# PATIENT MEDICAL HISTORY

Patient_____ Date_____ Occupation_____

DOB_____ AGE_____ SEX: MALE FEMALE RACE: AFRICAN AMERICAN HISPANIC ASIAN CAUCASIAN OTHER

Drug allergies/sensitivity/intolerances_____

_____

Do you have any of the following diagnosis?

Mark Appropriate box for **BLOOD RELATIVES** Column
**F** – Father **M** – Mother **B** – Brother **S** – Sister

| | PERSONAL YES | PERSONAL NO | EXPLAIN | BLOOD RELATIVES |
|---|---|---|---|---|
| Asthma / Emphysema | | | | |
| Heart Attack / Arrhythmia | | | | |
| High Blood Pressure | | | | |
| Arthritis | | | | |
| Eczema / Psoriasis / Rosacea | | | | |
| Migraines | | | | |
| Stroke | | | | |
| Ulcers / Crohn's | | | | |
| Thyroid Disease | | | | |
| Diabetes-Insulin / Non-Insulin | | | | |
| High Cholesterol | | | | |
| Leukemia / HIV / Hepatitis | | | | |
| Sjogren's / Lupus | | | | |
| Cancer | | | | |
| Any other medical diseases? | | | | |
| | | | | |
| Surgeries - other than eyes, please list | | | | |
| | | | | |

**Do you smoke?** Yes No If *YES*, how much? packs/day **Do you consume alcohol:** Yes No If *YES*, how often?

**Do you exercise?** none / occasional / often **Driving:** Yes No

Are you having or have you ever had any of the following?

| | PERSONAL YES | PERSONAL NO | DATE | BLOOD RELATIVE |
|---|---|---|---|---|
| Eye Injury | | | | |
| Double Vision | | | | |
| Flashing Lights / Floaters | | | | |
| Decreased / Blurred Vision | | | | |
| Halos / Foggy Vision | | | | |
| Cataracts | | | | |
| Glaucoma | | | | |
| Lazy eye - poor childhood vision, patched as a child | | | | |
| Retinal Detachment | | | | |
| Diabetic Retinopathy | | | | |
| Macular Degeneration | | | | |
| Blepharitis | | | | |
| Other Eye Diseases | | | | |
| Ocular Surgery/Notes: | | | | |

**Do you currently have any problems in the following areas?**

| IF YES, PLEASE PROVIDE INFORMATION | YES | NO | DETAILS |
|---|---|---|---|
| **Eyes:** (blur, glare, red, pain, etc.) | | | |
| **General / Constitutional:** (fever, weight loss, etc.) | | | |
| **Ears, Nose, Throat:** (ear ache, stuffy nose, cough, dry mouth) | | | |
| **Cardiovascular:** (racing pulse, palpitations, chest pains) | | | |
| **Respiratory:** (congestion, wheezing, etc.) | | | |
| **Gastrointestinal:** (stomach pain, diarrhea, constipation) | | | |
| **Genital, Kidney, Bladder:** (painful urination, impotence, etc.) | | | |
| **Muscle, Bones, Joints:** (joint pain, stiffness, swelling, cramps) | | | |
| **Skin:** (pimples, warts, growths, rash) | | | |
| **Neurological:** (numbness, headaches, etc.) | | | |
| **Psychiatric:** (anxiety, depression, insomnia) | | | |
| **Allergic / Immunologic:** (sneezing, swelling, redness, itching) | | | |

| Date History Reviewed | No Changes Noted by Patient | CHANGES ARE LISTED HERE | REVIEWED BY: (Initials Dr / Tech) |
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TECH SIGNATURE _____ DATE _____ PHYSICIAN SIGNATURE _____