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)

TECH SIGNATURE _____ DATE _____ PHYSICIAN SIGNATURE _____