EYE M.D. MONTEREY

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Patient Name:_____ Date of Birth_____ Today's Date:_____

REVIEW OF SYSTEMS

Please indicate if any of the following apply to your current health:

Constitutional
- ❑ Fever
- ❑ Fatigue
- ❑ Weight Loss
- ❑ Chills

Note:_____

FEMALES:
Pregnant/nursing? Yes ❑ No ❑

Note:_____

Allergic / Immunologic
- ❑ Hives
- ❑ Hay fever
- ❑ Eczema

Note:_____

Endocrine
- ❑ Diabetes
- ❑ Thyroid
- ❑ Cholesterol
- ❑ Heat/Cold intolerance

Note:_____

Ear, Nose, Throat
- ❑ Sore throat
- ❑ Sinus trouble
- ❑ Stuffy nose
- ❑ Hearing loss

Note:_____

Psychiatric
- ❑ Anxiety
- ❑ Mood swings
- ❑ Depression
- ❑ Difficulty Sleeping

Note:_____

Neurological
- ❑ Headaches
- ❑ Memory Loss
- ❑ Paralysis
- ❑ Loss of strength
- ❑ Numbness

Note:_____

Musculoskeletal
- ❑ Back Pain
- ❑ Joint pain/Swelling
- ❑ Stiffness
- ❑ Muscle pain

Note:_____

Hematology/Lymph
- ❑ Anemia
- ❑ Bruising easily
- ❑ Enlarged Glands
- ❑ Gums bleeding easily

Note:_____

Genitourinary
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Painful urination
- ❑ Abnormal discharge
- ❑ Bladder leakage

Note:_____

GENERAL MEDICAL HISTORY

Please indicate if any of the following apply to your general medical history:

- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Blood Transfusion
- ❑ Breast Cancer
- ❑ Cancer, colon
- ❑ Cancer, lung
- ❑ Cancer, skin
- ❑ Cancer, Other
- ❑ Congestive heart failure
- ❑ COPD
- ❑ Dementia
- ❑ Elevated Cholesterol
- ❑ Heart Attack
- ❑ HIV
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Pacemaker
- ❑ Stroke
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Other: _____

PAST SURGERIES / ALLERGIES

Please list any previous surgeries:

SURGERY	YEAR OF SURGERY

Please list any allergies:

ALLERGIES	REACTION

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FAMILY HISTORY

Please indicate if any of the following apply to your family history:

❑ **Family History Unknown**

Eye Problems

❑ Blindness
❑ Glaucoma
❑ Cataracts
❑ Corneal Disease
❑ Keratoconus
❑ Corneal transplant
❑ Macular degeneration
❑ Diabetic Retinopathy
❑ Retinal Detachment
❑ Retinitis Pigmentosa
❑ Other Eye Problems
_____
_____

Medical Problems

❑ Cancer
❑ Diabetes
❑ Thyroid
❑ Hypertension
❑ Stroke
❑ Heart Disease
❑ Other Health Conditions:
_____
_____
_____

SOCIAL HISTORY

Occupation: _____

Important vision-related activities: _____

	Yes	No	
Do you drink Alcohol?	❑	❑	If YES, how much? _____
Do you smoke?	❑	❑	If YES, how much? _____
Did you smoke in the past?	❑	❑	For how many years? _____

OCULAR HISTORY

Please indicate if any of the following apply to your ocular history:

❑ Amblyopia
❑ Astigmatism
❑ Blepharitis
❑ Blindness
❑ Cancer
❑ Cataract
❑ Chalazion
❑ Contact lenses
❑ Corneal Abrasion
❑ Corneal Ulcer
❑ Diabetic retinopathy
❑ Diplopia (double vision)
❑ Dry eyes
❑ Ectropion
❑ Entropion
❑ Epiretinal membrane
❑ Eyelid lesion
❑ Glaucoma
❑ Herpes simplex
❑ Herpes Zoster
❑ Hyperopia (far sighted)
❑ Keratoconus
❑ Lasik
❑ Macular degeneration
❑ Macular hole
❑ Myopia (near sighted)
❑ Ocular trauma
❑ Posterior vitreous detachment
❑ PRK
❑ Pterygium
❑ Ptosis (droopy eyelid)
❑ Retinal detachment
❑ Strabismus
❑ Uveitis

❑ Other: _____

MEDICATIONS

Please list any medications you are currently taking:

MEDICATION	DOSAGE	MEDICATION	DOSAGE

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