MEDICAL HISTORY

Abrams EyeCare ASSOCIATES

Date: _____

Patient Name: _____ **Date of Birth:** _____

Primary Care Physician: _____

CURRENT EYE SYMPTOMS

	Yes / No		Yes / No		Yes / No		Yes / No
Blurred Vision	☐ ☐	Burning	☐ ☐	Discharge	☐ ☐	Flashes of Light	☐ ☐
Loss of Vision	☐ ☐	Tearing	☐ ☐	Pain	☐ ☐	Floaters/Spots in Vision	☐ ☐
Redness	☐ ☐	Itching	☐ ☐	Dry Eyes	☐ ☐	Glare/Halos around Lights	☐ ☐

REVIEW OF SYSTEMS - Please answer YES or NO for each question

	Yes / No		Yes / No		Yes / No
Fever	☐ ☐	Chest Pain	☐ ☐	Rash	☐ ☐
Fatigue	☐ ☐	Irregular Heartbeat	☐ ☐	Joint Pain / Swelling	☐ ☐
Dizziness	☐ ☐	Abdominal Pain	☐ ☐	Muscle Weakness	☐ ☐
Hearing Loss	☐ ☐	Nausea / Vomiting	☐ ☐	Bleeding / Bruising Easily	☐ ☐
Nasal Congestion	☐ ☐	Increased Urination	☐ ☐	Depression	☐ ☐
Sore Throat	☐ ☐	Increased Thirst	☐ ☐	Food Allergies	☐ ☐
Cough	☐ ☐	Cold / Heat Intolerance	☐ ☐	Environmental Allergies	☐ ☐
Shortness of Breath	☐ ☐			Seasonal Allergies	☐ ☐

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING EYE MEDICATIONS)

Medication Name	Dosage	Medication Name	Dosage

Are you allergic to any medications: ☐ Yes ☐ No _____

OCULAR HISTORY:

	Yes / No		Yes / No		Yes / No		Yes / No
Cataracts	☐ ☐	Macular Degeneration	☐ ☐	Retinal Detachment	☐ ☐	Laser Treatment (LASIK)	☐ ☐
Glaucoma	☐ ☐	Crossed / Lazy Eyes	☐ ☐	Injury	☐ ☐	Surgery	☐ ☐

Eye Surgery / Other Procedures? _____

_____

MEDICAL HISTORY

	Yes / No		Yes / No		Yes / No		Yes / No
Diabetes ___yrs __I __ II	☐ ☐	Stroke/Heart Disease	☐ ☐	Cancer	☐ ☐	Lung Problems	☐ ☐
High Blood Pressure	☐ ☐	Migraines	☐ ☐	Thyroid	☐ ☐	Kidney Disease	☐ ☐
Ear/Nose/Throat/Sinus	☐ ☐	Skin Disorders	☐ ☐	Arthritis	☐ ☐	Immune Disorders	☐ ☐

Surgery / Other Procedures? _____

_____

FAMILY HISTORY - Has anyone in your family had any of the following

☐ Cataracts ☐ Macular Degeneration ☐ Glaucoma ☐ Retinal Detachment ☐ Diabetes

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No Packs/Day ____ Years____ If no, did you ever smoke? ☐ Yes ☐ No Packs/Day____ Years____