OHIO EYECARE SPECIALISTS, INC
MEDICAL HISTORY FORM

Patient's Name:	**Age:**	**Today's Date:** / /
Name of Family Doctor:		**Date of Last Physical:** / /
Name of Last Eye Doctor:		**Date of Last Eye Exam:** / /
Name of Referring Doctor:	**Allergies:**	

MEDICAL HISTORY - PLEASE CHECK ANY ILLNESSES YOU HAVE, OR HAVE HAD IN THE PAST

- ☐ Diabetes Last BS:____________
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Thyroid Disease/ Goiter
- ☐ Heart Disease / Heart Attack
- ☐ Stomach or Bowel Disorder
- ☐ Arthritis (Rheumatoid, Lupus, Sjogrens)
- ☐ Ulcers
- ☐ Migraines
- ☐ Kidney / Urinary Problems
- ☐ Smoke ___Packs a Day__Yrs
- ☐ Lung Disease / Asthma
- ☐ Cancer Where: ___________
- ☐ Hepatitis circle A B C
- ☐ HIV/AIDS
- ☐ Alcohol Use
- ☐ Drug Abuse
- ☐ Depression
- ☐ Nervous Condition
- ☐ Bleeding Disorder

REVIEW OF SYSTEMS – PLEASE CHECK ANY CURRENT SYMPTOMS YOU ARE EXPERIENCING

- ☐ Chronic Fever, unexpected weight loss / gain, fatigue
- ☐ Ear, nose or throat problems (ie: hearing loss, sinus problems, sore throat)
- ☐ Heart problems (ie: chest pain, irregular heart beat)
- ☐ Respiratory Problems (ie: shortness of breath, wheezing, coughing)
- ☐ Gastrointestinal Problems (ie: heartburn, abdominal pain, diarrhea, vomiting)
- ☐ Urinary Problems (ie: pain or discomfort, blood in urine)
- ☐ Skin Problems (ie: rashes, excessive dryness)
- ☐ Musculoskeletal problems (ie: muscle aches, joint pain, swollen joints)
- ☐ Neurological Problems (ie: weakness, headaches, paralysis
- ☐ Psychiatric Problems (ie: depression, anxiety)

List of Medications Including Eyedrops:		List any Surgeries or Hospitalizations with Date:
1.	5.	1.
2.	6.	2.
3.	7.	3.
4.	8.	4.

EYE HISTORY - PLEASE MARK ANY EYE SYMPTOMS OR DISEASES YOU HAVE:

Right	Left		Right	Left	
☐	☐	Eye(s) Burn, Feel Dry or Scratchy	☐	☐	Glaucoma
☐	☐	Tearing from Eye(s)	☐	☐	Cataracts
☐	☐	Blurred Vision	☐	☐	Retinal Detachment
☐	☐	Double Vision	☐	☐	Diabetic Retinopathy
☐	☐	Blindness / Poor Vision	☐	☐	Crossed / Wandering Eye(s)
☐	☐	Floaters / Flashes of Light	☐	☐	Lazy Eye (Amblyopia)
☐	☐	Eyelid, Eyeball growths or bumps	☐	☐	Color Blindness
☐	☐	Eye Injury Date: ______________________ Explain Injury: ________________________	☐	☐	Eye Surgery Date: ___________ Explain Surgery: ____________

FAMILY HISTORY - DOES ANYONE IN YOUR FAMILY HAVE:

☐ Retinal Detachment ☐ Cataracts ☐ Glaucoma ☐ Lazy Eye(s) ☐ Blindness ☐ Other: ______

Is there anything you would like to bring to the Doctor's attention? ____

____

____________	______________________________	________________________	______
Date	Patient Signature	Dr. Signature	Tech