STUART EYE INSTITUTE

Complete Medical History

Name_____ **Date** _____

Local Physician_____ **Sex**_____ **Weight**_____ **Date of Birth** _____

GLASSES Do you wear glasses for: Distance Y N Reading Y N Bifocal Y N

Computer or other special need (piano, organ, etc.) Y N

CONTACT LENSES Y N Distance - Monovision - Bifocal _____

SOCIAL HISTORY

Current or Previous Occupation _____

What is your primary language (if not English) _____

Do you smoke? Y N amount_____ **If No, did you smoke in the past? Y N**

Do you drink alcohol Y N —> If yes, list amount per week_____

Do you drive? Y N Do you live alone? Y N

EYE HISTORY - Have you or any of your blood related family members had any of the following?

SELF			FAMILY MEMBER			RELATION
Cataracts	Y	N	Cataracts	Y	N	_____
Glaucoma	Y	N	Glaucoma	Y	N	_____
Diabetes	Y	N	Diabetes	Y	N	_____
Retinal Detachment	Y	N	Retinal Detachment	Y	N	_____
Macular Degeneration	Y	N	Macular Degeneration	Y	N	_____
Eye Surgery	Y	N	Eye Surgery	Y	N	_____

MEDICATIONS - prescription and non prescription (name and dose - or attach list)

	Drug Name	Dose		Drug Name	Dose
1	_____	_____	6	_____	_____
2	_____	_____	7	_____	_____
3	_____	_____	8	_____	_____
4	_____	_____	9	_____	_____
5	_____	_____	10	_____	_____

PLEASE COMPLETE THE OTHER SIDE –>

ALLERGIES - To Medications, Foods and Others

_____

PAST MEDICAL HISTORY - Please indicate whether you have had any of the following medical problems.

CHEST LUNGS

Asthma/Wheezing	Y	N
Emphysema	Y	N
Shortness of Breath	Y	N

Other _____

EXTREMITIES

Arthritis	Y	N

HEART/CARDIOVASCULAR

Angina Syndrome	Y	N
Heart Attack	Y	N
Carotid Disease	Y	N
Congestive Heart Failure	Y	N
Cardiac Arrhythmia	Y	N
Circulation Problems	Y	N
High Blood Pressure	Y	N

Other _____

ENDOCRINNE

Thyroid Disease	Y	N
Diabetes	Y	N

Other _____

GENITOURINARY

Kidney Stones	Y	N

Other _____

NEUROLOGICAL

Previous Stroke or TIA	Y	N
Headache	Y	N
Seizures	Y	N

Other _____

PSYCHIATRIC

Psychiatric Episode	Y	N

Describe _____

HEMATOLOGIC

Bleeding Disorder	Y	N

Other _____

GASTROINTESTINAL

Hepatitis	Y	N
Ulcers, GERD	Y	N

Other _____

IMMUNOLOGIC

Immune Deficiency	Y	N

Other _____

CANCER

Describe _____

SKIN

Shingles	Y	N
Melanoma	Y	N

LIST ANY SURGERY, HOSPITALIZATIONS, AND SERIOUS ILLNESSES OR ACCIDENTS NOT LISTED ABOVE _____

_____

_____

_____

FAMILY HISTORY - Mother, Father, Grandparent or Sibling - List serious medical diseases affecting your family members: _____

_____

Reviewed by

TECH	PATIENT	PHYSICIAN	DATE
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___
_____	_____	_____	___/___/___