



PATIENT MEDICAL HISTORY

Last Name _____ First Name _____ MI _____ Age _____

Home Phone _____ Primary Care Physician _____

Your Pharmacy & Location _____ Pharmacy Phone _____

Medical Status and History Circle YES or NO, if YES, please explain

1. Have you been treated for any medical conditions (diabetes, high blood pressure, arthritis)? YES NO
If Yes, please explain _____
2. Have you had any **EYE** disease (glaucoma, cataract, "lazy" eye, retinal detachment)? YES NO
If Yes, provide date(s) & reason _____
3. Have you ever been hospitalized? YES NO
If Yes, provide date(s) & reason _____
4. Have you had any **EYE** surgery (cataract, glaucoma, "lazy" eye, retinal detachment)? YES NO
If Yes, provide date(s) & reason _____
5. Have you had other medical surgery? YES NO
If Yes, provide date(s) & reason _____
6. **List** the **EYE** medications you take, if any? _____

7. **List** other medications you take? **Bring them to your appointment.** _____

8. Do you have any food or drug allergies? YES NO
If Yes, please list _____

Do you currently have any of the following problems? Circle YES or NO, if YES, please explain

1. Chronic fever, unexpected weight loss/gain, fatigue YES NO _____
2. Ear/nose/throat problems (hearing loss, sinus problems, sore throat). . . . YES NO _____
3. Heart problems (chest pain, irregular heart beat). YES NO _____
4. Respiratory problems (shortness of breath, wheezing, coughing. YES NO _____
5. Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting) . YES NO _____
6. Urinary problems (pain or discomfort, blood in urine). YES NO _____
7. Skin problems (rashes, excessive dryness) YES NO _____
8. Musculoskeletal problems (muscle aches, joint pain, swollen joints) YES NO _____
9. Neurological problems (numbness, weakness, headaches, paralysis). YES NO _____
10. Psychiatric problems (depression, anxiety). YES NO _____

Family and Social History

1. Do any medical or eye diseases run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration)? _____ If yes, please explain _____
2. Do you smoke? _____ If yes, how much _____
3. Do you drink alcohol? _____ If yes, how much? _____
4. How much do you use a computer on a regular basis? _____

Signature of patient or legal representative

Signature of Dr. Haines

Date