

# EYE ASSOCIATES OF WILMINGTON, P.A.

## Patient Medical History & Review of Systems

ROS/PFSH reviewed  
 Date \_\_\_\_ By \_\_\_\_  
 Date \_\_\_\_ By \_\_\_\_  
 Date \_\_\_\_ By \_\_\_\_  
 Date \_\_\_\_ By \_\_\_\_  
 Date \_\_\_\_ By \_\_\_\_  
 Date \_\_\_\_ By \_\_\_\_

Patient Name: \_\_\_\_\_ Chart # \_\_\_\_\_ Date \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_ Did a doctor refer you? \_\_\_\_ If so, who? \_\_\_\_\_

### Past Medical History

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (type, when diagnosed) _____
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease (asthma, emphysema, COPD, chronic bronchitis)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (list type or location) _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease (explain) _____
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure (explain) _____
<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery: Date/Reason _____ _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Other Surgery: Date/Reason _____ _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Other problems/injuries _____ _____ _____ _____

### Do you have any of these problems?

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease (heart attack, angina, arrhythmia, heart failure, heart valve dz, bypass surgery)
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn, abdominal pain, diarrhea, vomiting, weakness, numbness
<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat (hearing loss, sinus disease)
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease (hypo, hyper, Graves' disease)
<input type="checkbox"/>	<input type="checkbox"/>	Blood Problems (anemia, leukemia, clotting problems)
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disease (ulcers, esophageal reflux, intestinal)
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary Disease (kidney disease, dialysis, kidney stones)
<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems (eczema, psoriasis, acne rosacea)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (rheumatoid, osteodegenerative), joint pain
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems (depression, anxiety, schizophrenic, bipolar)
<input type="checkbox"/>	<input type="checkbox"/>	Neurological Problems (stroke, seizure, paralysis)
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory (shortness of breath, wheezing, coughing)

### OPHTHALMIC HISTORY

	Yes	No
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Corneal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Eye Prob	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Iritis	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degen	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detach	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____ _____		
Injury/Date: _____ Nature: _____ _____ _____		

### FAMILY HISTORY

	Father	Mother	Siblings	Other
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
↑ BP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____				

### SOCIAL HISTORY (circle)

Marital Status	M	S	D	W
Live Alone	Y	N		
Tobacco	Y	N		
Alcohol	Y	N		
Occupation _____			Retired	
Hobbies _____				

### LIST YOUR MEDICATIONS:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### EYE MEDICATIONS:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### ALLERGIES:

\_\_\_\_\_  
 \_\_\_\_\_