Ophthalmology Associates, Ltd

Patient Medical History

Patient's Name_________________________________ **Today's Date**_______

MEDICAL HISTORY: Please list any major illnesses, hospitalizations and injuries?

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Medication Allergies: (Please List Drug and Reaction):

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Family History: Have there been any NEW eye problems in the family? □No □Yes (if yes give details)

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Review of Systems: (Are you currently experiencing any of the following symptoms?)

Endocrine (diabetes, thyroid) □No □Yes___________________________________
Chronic fever, fatigue, weight loss □No □Yes _____________________________
Ear, Nose, Throat Problems □ No □Yes____________________________________
Allergies (food, environmental) □No □Yes__________________________________
Cardiovascular (blood pressure, pulse) □No □Yes___________________________
Respiratory (asthma, cough) □No □Yes____________________________________
Gastrointestinal (nausea, vomiting, bowel problems) □No □Yes_______________
Kidney, Bladder □No □Yes____
Muscles, Joints, Bones (arthritis, pains) □No □Yes__________________________
Skin (rashes, moles) □No □Yes____
Neurological (headaches, weakness, habits) □No □Yes________________________
Psychiatric (anxiety, depression, insomnia) □No □Yes_______________________
Blood (anemia, bleeding problem □No □Yes_______________________________

Patient Signature: ____