MidShore Surgical Eye Center
Medical History & Review of Systems

Name:____________________________________ Date:______________

Date of birth:_________________

Do you have or have you ever had:

	Yes	No
Allergies	___	___
To what? ____________________________		
____________________________		
Eye problems:		
-glaucoma	___	___
-cataracts	___	___
-macular degeneration	___	___
Diabetes	___	___
If yes:		
When were you diagnosed? ___________		
Do you take insulin?	___	___
High blood pressure	___	___
Heart attack	___	___
Heart disease	___	___
Arthritis	___	___
Cancer	___	___
Migraine headaches	___	___
Thyroid disease	___	___
Stroke	___	___
Lung disease (fibrosis/emphysema COPD)	___	___
Asthma	___	___
Kidney disease	___	___
HIV	___	___
Tuberculosis (TB)	___	___
Syphilis	___	___
Any surgery	___	___
Please specify:		

____
____

Other medical problems: ____
____
____
____
____

Family History

Does anyone in your family have?

	Yes	No
Diabetes	___	___
High blood pressure	___	___
Heart attack	___	___
Heart disease	___	___
Arthritis	___	___
Cancer	___	___
Migraine headaches	___	___
Thyroid disease	___	___
Stroke	___	___
Lung disease (Fibrosis/emphysema COPD)	___	___
Asthma	___	___
Kidney disease	___	___
HIV	___	___
Tuberculosis (TB)	___	___
Eye problems/blindness		
-glaucoma	___	___
-macular degeneration	___	___
-blindness	___	___

Social History:

Occupation____________________________

	Yes	No
Do you smoke?	___	___
How much per day:_________________		
Do you drink?	___	___
How much?_____________________		
Have you ever used Drugs?	___	___

Name:___________________________________ Date of birth:______________

Review of Systems:

	yes	no
1.Eyes		
Blurred Vision	___	___
Double Vision	___	___
Redness	___	___
Dry, Itchy, Scratchy	___	___
Excessing Tearing	___	___
Swelling	___	___
2.Constitutional		
Weight loss	___	___
Fatigue	___	___
Fever	___	___
3. Cardiovascular		
High Blood Pressure	___	___
Circulation Problems	___	___
Cholesterol Treatment	___	___
Feet / Ankle Swelling	___	___
4. Endocrine		
Excessive thirst	___	___
Diabetic	___	___
Thyroid Disease	___	___
5. Respiratory		
Chronic Bronchitis	___	___
Asthma	___	___
Emphysema	___	___
Cough / Wheeze	___	___
Shortness of Breath	___	___
6. Neurological		
Headaches	___	___
Seizures	___	___
Weakness	___	___
Numbness	___	___

7. Ears/Nose/Throat	yes	no
Change in hearing	___	___
Hearing aid use	___	___
Sinus problems	___	___
Sore throat	___	___
8. Blood and Lymph		
Easy bruising	___	___
Swollen lymph nodes	___	___
9. Skin		
Rash	___	___
Lesions	___	___
10. Gastrointestinal		
Stomach pain	___	___
Heartburn	___	___
Nausea	___	___
Vomiting	___	___
11. Muscles/Bones		
Arthritis	___	___
Weakness	___	___
Easily broken bones	___	___
Joint Pain	___	___
12. Psychiatric		
Depression	___	___
Nervousness	___	___
13. Allergic		
Seasonal Allergies	___	___
Hay fever	___	___
14. Genitourinary		
Bladder Infections	___	___
Kidney Problems	___	___