montana retina CONSULTANTS

MEDICAL HISTORY SHEET

Name _____ Date_____ Age_____ Race_____

What is the main problem that brings you here? _____

In which eye? _____ For how long? _____

(Check YES or NO for all questions and explain, if necessary, under EXPLANATION)

EYE HISTORY	**YES**	**NO**	**EXPLANATION**
Have you ever had a lazy or crossed eye?	_____	_____	_____
Have you ever had an eye injury?	_____	_____	_____
Do you wear glasses or contacts?	_____	_____	_____
How old is the prescription?	_____	_____	_____
Have you ever had double vision?	_____	_____	_____
Do you have any history of glaucoma?	_____	_____	_____
Have you ever had eye surgery, including laser?	_____	_____	_____
If so, please list…..	_____	_____	_____
Do you use any eye drops, ointments, or pills for eye disease? Please list…	_____		
	_____		
	_____		

DEVELOPMENT HISTORY			
Were you born prematurely?	_____	_____	_____
(if yes, birth weight and if on oxygen)	_____		

PAST MEDICAL HISTORY			
Are you in good general health?	_____	_____	_____

Any allergies to drugs, dyes or foods?	_____	_____	_____
Do you take and medications? (List)	_____	_____	_____
Ever had any operation? (other than eye)	_____	_____	_____
Ever been in the hospital for a serious problem?	_____	_____	_____
Do you take aspirin on a regular basis?	_____	_____	_____
Names, addresses and phone numbers of all your medical doctors?	_____	_____	_____
Do you use tobacco products? If yes, explain	_____	_____	_____
Do you use alcohol or drugs? If yes, explain	_____	_____	_____
Do you consume drinks w/ caffeine? How much?	_____	_____	_____

EARS, EYES, NOSE, THROAT

Ever had sinus infections?	_____	_____	_____
Ever had ringing in the ears?	_____	_____	_____
Ever had loss of smell?	_____	_____	_____

NERVOUS SYSTEM

Ever had severe headaches?	_____	_____	_____
Ever had temporary blindness?	_____	_____	_____
Ever had any type of seizure?	_____	_____	_____
Ever had any numbness or unusual weakness?	_____	_____	_____
Ever been diagnosed with multiple sclerosis (MS)?	_____	_____	_____

CARDIOVASCULAR

Ever been told you have high blood pressure?	_____	_____	_____
Ever had a heart attack or heart disease?	_____	_____	_____
Ever had fluttering or palpitations of the heart?	_____	_____	_____
Ever had shortness of breath with exertion?	_____	_____	_____
Ever had chest pain?	_____	_____	_____
Ever had swelling of the feet or ankles?	_____	_____	_____
Ever had blood clots or vein inflammation?	_____	_____	_____
Ever had a stroke?	_____	_____	_____

RESPIRATORY

Ever had asthma?	_____	_____	_____
Any history of emphysema?	_____	_____	_____

Any problems with shortness of breath?	_____	_____	_____
Any other respiratory diseases?	_____	_____	_____

GASTROINTESTINAL

Ever had heartburn, indigestion, or stomach pain after eating, or ulcers?	_____	_____	_____
Ever been diagnosed with stomach problems or any intestinal disease?	_____	_____	_____

GENITORINARY

Any previous diagnosis of kidney disease or problems with urination?	_____	_____	_____
Do you take birth control pills?	_____	_____	_____
Are you pregnant?	_____	_____	_____

ENDOCRINE

Have you ever had thyroid problems?	_____	_____	_____
Ever been told you have sugar diabetes?	_____	_____	_____
If yes, what age diagnosed and how long?	_____	_____	_____
Do you take insulin? How long?	_____	_____	_____
Do you take diabetic pills? How long?	_____	_____	_____
What is your average blood sugar?	_____	_____	_____
How often is your blood sugar checked?	_____	_____	_____
Have you ever been hospitalized for high or low blood sugar?	_____	_____	_____

INFECTIOUS/INFLAMMATORY/OTHER DISEASES

Any problems with arthritis?	_____	_____	_____
Any history of TB or exposure to TB?	_____	_____	_____
Any history of cancer?	_____	_____	_____
Ever diagnosed with sickle cell anemia?	_____	_____	_____
Ever had syphilis or venereal disease?	_____	_____	_____
Ever been diagnosed with hepatitis?	_____	_____	_____
Ever had a blood transfusion?	_____	_____	_____
Ever had a positive IV test/exposure to AIDS?	_____	_____	_____
When was the last date of your last tetanus shot?	_____	_____	_____

FAMILY HISTORY

Has any member of our family had cataracts?	_____	_____	_____
Glaucoma?	_____	_____	_____
Detached retina?	_____	_____	_____
Macular degeneration?	_____	_____	_____
Blindness or decreased vision?	_____	_____	_____
Cross eye or lazy eye?	_____	_____	_____
Diabetes? If yes, what age?	_____	_____	_____
Cancer?	_____	_____	_____
Any other serious health problems?	_____	_____	_____

PT Name: _____

Additional Clinical Comments: (For office use only)

Date: Medical Update (For office use only)