MONTGOMERY EYE CENTER

Comprehensive Medical History

Name: (Mr, Mrs, Miss) _____ Date of Birth: _____

Date: _____ Primary Physician: _____

Pharmacy Location and Phone Number: _____

Date of Last Eye Exam: _____ □ local eye doctor □ out of state eye doctor

Medications List all medications, vitamins, or supplements (including strength and how often).

_____ _____

_____ _____

_____ _____

_____ _____

Allergies Latex? □ Yes □ No Iodine? □ Yes □ No Medications? □ Yes □ No

List any and their reactions: _____

_____

Past Medical History (check any boxes that apply)

Cardiovascular
- □ Heart Attack
- □ Heart Disease
- □ High Blood Pressure
- □ High Cholesterol
- □ Atrial Fibrillation
- □ Pacemaker
- □ Other _____

Endocrine
- □ Diabetes – insulin dependent
- □ Diabetes – not using insulin
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Pituitary/Adrenal
- □ Other _____

Musculoskeletal
- □ Arthritis
- □ Fibromyalgia
- □ Osteoporosis
- □ Osteoarthritis
- □ Polymyalgia Rheumatica
- □ Rheumatoid Arthritis
- □ Other _____

Respiratory
- □ Asthma
- □ COPD
- □ Emphysema
- □ Sleep Apnea
- □ Cystic Fibrosis
- □ Other _____

Gastrointestinal
- □ Hepatitis A, B, C
- □ Crohn's Disease
- □ Constipation
- □ Diarrhea
- □ Ulcers
- □ Other _____

Integumentary
- □ Dermatitis
- □ Eczema
- □ Psoriasis
- □ Bruising
- □ Other _____

Neurological
- □ Migraines
- □ Stroke
- □ Bell's Palsy
- □ Headaches
- □ TIA (mini-stroke)
- □ Other _____

Cancer
- □ Breast
- □ Prostate
- □ Colon
- □ Carcinoma
- □ Melanoma
- □ Other _____

Other
- □ Depression/Anxiety
- □ Lupus
- □ Claustrophobia
- □ HIV
- □ Seasonal Allergies
- □ Other _____

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Previous Surgeries

List any past medical or eye-related surgeries below.

Date	Procedure	Surgeon

Social History

Tobacco? □ Yes □ Former Smoker □ Never Smoker How often? _____

Alcohol? □ Yes □ No How often? _____ **Drugs?** □ Yes □ No

Occupation: _____ Hobbies: _____

Personal Ocular History

			Date Diagnosed / Other Information
Glaucoma	□ Yes	□ No	_____
Macular Degeneration	□ Yes	□ No	_____
Retinal Disease	□ Yes	□ No	_____
Lazy Eye	□ Yes	□ No	_____
Cornea	□ Yes	□ No	_____
Cataracts	□ Yes	□ No	_____
Eye Trauma	□ Yes	□ No	_____
Lids	□ Yes	□ No	_____

Family History

			Relationship
Glaucoma	□ Yes	□ No	_____
Macular Degeneration	□ Yes	□ No	_____
Retinal Disease	□ Yes	□ No	_____
Lazy Eye	□ Yes	□ No	_____
Cataracts	□ Yes	□ No	_____
Blindness	□ Yes	□ No	_____
Diabetes	□ Yes	□ No	_____
Cancer	□ Yes	□ No	_____
Heart Disease	□ Yes	□ No	_____
High Cholesterol	□ Yes	□ No	_____
Stroke	□ Yes	□ No	_____