

**Medical & Ophthalmic history form**

*date updated* \_\_\_\_\_

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Primary care physician(s):** \_\_\_\_\_

**Current medications (please list)** \_\_\_\_\_ **Allergies (please list)** \_\_\_\_\_

1. \_\_\_\_\_ 6. \_\_\_\_\_ 1. \_\_\_\_\_

2. \_\_\_\_\_ 7. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 8. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 9. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 10. \_\_\_\_\_ 5. \_\_\_\_\_

**Social history: (please check yes or no)**

**Yes No**

**Do you smoke?** How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

**Do you drink alcohol?** How much & how often? \_\_\_\_\_

**Do you exercise?** What type & how often? \_\_\_\_\_

**Animal or pet contact?** Please describe \_\_\_\_\_

**Occupation?** \_\_\_\_\_ **If retired, previous occupation?** \_\_\_\_\_

**Residence(s) other than Hawaii?** \_\_\_\_\_

**Family History: Does any family member have any of the following problem?**

**Yes No**

**Diabetes** whom? \_\_\_\_\_

**Glaucoma** whom? \_\_\_\_\_

**Macular degeneration** whom? \_\_\_\_\_

**Retinal detachment** whom? \_\_\_\_\_

**Other significant eye problems? (Please list)** \_\_\_\_\_

**Past Eye history: Do you have any of the following eye problem, if yes, which eye & what year diagnosed?**

**Yes No**

**Cataract**

**Glaucoma**

**Macular degeneration**

**Diabetic retinopathy**

**Retinal detachment**

**Please list past eye surgery (type, right/left eye, what facility, when and surgeon's name).**

**Review of systems**

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
<b>Loss/gain of weight?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Ulcers?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Migraines?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lack of energy?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Anemia</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Depression?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hearing deficit ?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Kidney stones?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Anxiety?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Decreased vision?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Dialysis?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Diabetes?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sinus trouble?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Arthritis?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Thyroid?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>High blood pressure?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gout?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Cancer?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Chest pains?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Rash?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>(type/treatment)</b>		
<b>Palpitations?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Stroke?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>TB?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Asthma?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Seizures?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hepatitis?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Long standing cough?</b>	<input type="checkbox"/>	<input type="checkbox"/>				<b>HIV?</b>	<input type="checkbox"/>	<input type="checkbox"/>

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_