Ophthalmology Associates, P.S.C.
Adult Medical History

Name:____________________DOB:________Age:________Date:________

History of Eye Diseases: (Please Circle)

Glaucoma Cataract Macular Degeneration Eye Injury
Amblyopia Strabismus Corneal Disorder Other____________________

Eye Surgery/Laser Procedures:____________________
____

Name of Medical Doctor:____________________

List all present medications and doses:____________________
____

Allergies:____________________

Review of Systems:

Arthritis	Yes	No____________________
Asthma, Emphysema, COPD	Yes	No____________________
Cancer	Yes	No____________________
Diabetes Mellitus	Yes	No IDDM Yes No Duration:_____HgA1C:______
Kidney/Liver	Yes	No____________________
Gastrointestinal	Yes	No____________________
Hearing Loss	Yes	No____________________
Heart Disease	Yes	No____________________
High Blood Pressure	Yes	No____________________
HIV	Yes	No CD-4#:____________________
Neurological	Yes	No____________________
Psychiatric	Yes	No____________________
Thyroid	Yes	No____________________

Trauma:____________________

Other medical problems (specify)____________________

List all surgeries and dates:

1.____________________ Date:________ 4.____________________ Date:________
2.____________________ Date:________ 5.____________________ Date:________
3.____________________ Date:________ 6.____________________ Date:________

Social History:

Smoking	Yes	No	Duration/Number of packs:____________________
Do you drink alcohol	Yes	No	Daily Occasionally Rarely Never
Patient lives alone	Yes	No	____________________

Family History:

Glaucoma:	Yes	No	____________________
Cataract:	Yes	No	____________________
Other Eye Disease:	Yes	No	____________________
Diabetes:	Yes	No	____________________

Other:____________________

History Reviewed with Patient:____________________Signature____________Date
____________________Signature____________Date