GURLEY EYE CARE ASSOCIATES

MEDICAL HISTORY and REVIEW OF SYSTEMS

NAME: _____ **Gender: M / F**

ADDRESS: _____ **Social Security #:** _____

CITY, ST, ZIP: _____ **Marital Status:**

Telephone: _____ single__ married__ divorced__ widowed__

Date of Birth: _____ **Age:** _____ other_____

PLEASE COMPLETE IF UNDER 18 YEARS OF AGE, OR A FULL TIME STUDENT:

Name of Father: _____ Name of Mother: _____

Are you personally responsible for payment of your fees? If no, who is responsible?

Name: _____ Phone: _____

Address: _____

Street City State Zip

REASON FOR TODAY'S VISIT:

Primary Care Physician:

Name of pharmacy that you use:

Telephone of pharmacy:

Form completed by:
__patient __family __staff __other

FAMILY HISTORY: Among your **blood relatives**			**EXPLAIN:**
a. Glaucoma	No	Yes	
b. Cataracts	No	Yes	
c. "Lazy Eye" or muscle imbalance	No	Yes	
d. Retinal disease	No	Yes	
e. Macular disease	No	Yes	
f. Night blindness	No	Yes	
g. Color blindness	No	Yes	
h. Unexplained vision loss	No	Yes	
i. Diabetes mellitus	No	Yes	
j. Tumor or cancer	No	Yes	
k. High blood pressure	No	Yes	
l. High cholesterol	No	Yes	
m. Heart disease	No	Yes	
n. Bleeding disorder	No	Yes	

SOCIAL HISTORY:

1) Do you smoke? Yes__ No__ Did you ever smoke? Yes__ No__

2) If yes, how many cigarettes per day?_____ When did you stop? _____

3) Do you drink alcohol? Yes__ No__ Drinks per day _____ Drinks per week _____

4) Work Status:_____ Current occupation: _____

5) Any known toxic exposure? Yes__ No__

6) Living arrangements: home__ apartment__ nursing home__ other: _____

Do you live alone? Yes__ No__ Status: independent__ need assistance__

7) Do you drive in the day? Yes__ No__ With difficulty? Yes__ No__

Do you drive at night? Yes__ No__ With difficulty? Yes__ No__

8) Are there social problems affecting your health (family illness, deaths, stress, etc.)?

ALLERGIES: Medications, foods, chemicals, environment. *(Please describe reaction and when it occurred)*

MEDICATIONS: *(Give names, dosage and frequency)*

Eye Medications: _____

Prescription Medications: _____

Non-prescription Medication: _____

When did you last take aspirin in any form? _____

(OVER, PLEASE)

SURGERY: Have you had any previous **eye surgery / laser**, or injury? No___ Yes___ If yes, please give name(s) of operation(s) or injuries and date(s): _____

Date of last general anesthesia _____ Any anesthesia complication? Yes __ No__ Describe: _____

MEDICAL HISTORY: ***PLEASE CIRCLE PERTINENT RESPONSES*** **DATES / EXPLAIN:**

How would you rate your health? Poor Fair Good Excellent

Do you have now or have you ever had:

1) Fevers, chills, night sweats, unexplained fatigue? No Yes
2) Have you gained or lost more than 10 pounds in the last year? No Yes
3) Ear, nose, throat problems; loss of hearing, smell; sinus disease, vertigo, dry mouth, difficulty swallowing, bleeding? No Yes
4) Heart or circulation problems? No Yes
   heart attack, angina? No Yes
   congestive heart failure, shortness of breath? No Yes
   irregular or rapid heart beat? No Yes
   cardiac pacemaker or heart valve? No Yes
   high blood pressure? No Yes
   high cholesterol? No Yes
5) Respiratory problems? No Yes
   asthma? No Yes
   chronic cough; emphysema; bronchitis? No Yes
   tuberculosis; positive skin date _____ treatment? No Yes
6) Gastrointestinal problems? No Yes
   ulcers, diverticulitis, colitis, frequent diarrhea? No Yes
   liver disease, hepatitis (type_____)? No Yes
7) Genitourinary, kidney, bladder, prostate problems? No Yes
   stones, infections, frequency, VD? No Yes
8) Muscle weakness, inflammation, fatigue? No Yes
   arthritis, joint swelling, low back pain? No Yes
   osteoarthritis, rheumatiod, gout? No Yes
9) Skin, nail or hair problems; eczema, psoriasis, rosacea, infections? No Yes
10) Nervous systemic:
   TIA, stroke, seizures, difficulty walking, tremor, Parkinson's disease No Yes
   memory loss, disorientation, hallucinations, nervous breakdown, No Yes
   depression, anxiety No Yes
11) Diabetes No Yes
   Date of onset / Duration: _____
   Complications: kidney:____ neuropathy:____ vascular:____ ocular:____
   Treatment: diet:____ oral agents:____ insulin:____
12) Thyroid Disease underactive:____ overactive:____ treatment: _____
13) Adrenal:__ Pituitary:__ (*hair loss; unusual hand/foot growth; abnormal menstrual cycle; heat/cold intolerance; change in libido)*
14) Blood disorders: easy bruising__ anemia__ clot in legs__ recurrent infections__ swollen glands__
15) Transfusions of blood or plasma: _____
16) AIDS, ARC, or HIV positive test (give date): _____
17) Cancer or tumor: Type, location, date, treatment _____
18) If applicable, are you pregnant? Yes___ Expected Date of Delivery_____ No___
19) Other medical problems: _____

PATIENT SIGNATURE: _____ **Date:** _____

Reviewed by: _____ **Date:** _____