

NAME _____

DATE _____

MEDICAL HISTORY

ARE YOU BEING TREATED FOR:

YES NO

- DIABETES.....HOW LONG _____
- HIGH BLOOD PRESSURE
- HEART DISEASE OR HEART ATTACK
- ASTHMA,COPD,SHORTNESS OF BREATH
- STROKE
- KIDNEY STONES
- THYROID
- CANCER
- LUPUS, RHEUMATOID ARTHRITIS
- HIGH CHOLESTEROL
- HIV/AIDS
- HEPATITIS
- Have had or been treated for:
MRSA /BED BUGS/ SCABIES (Circle)

OTHER _____

FAMILY/SOCIAL HISTORY

- Blindness Mom/Dad/Brother/Sister
- Glaucoma Mom/Dad/Brother/Sister
- Diabetes Mom/Dad/Brother/Sister
- Heart Mom/Dad/Brother/Sister
- Cancer Mom/Dad/Brother/Sister
- Stroke Mom/Dad/Brother/Sister
- Arthritis Mom/Dad/Brother/Sister
- Other _____

Do you drink alcohol? Y / N

- ___ Occasionally
- ___ 1-2 per day
- ___ 3+ per day

Do you use Tobacco? Y / N

- _1/2 pk per day cigar / cigarette / pipe
- _1 pk per day chew tobacco (Circle)
- _1+ pk per day

REVIEW OF SYSTEMS

- Pregnant or nursing YES NO _____
- Fever /weight loss YES NO _____
- Ears, nose throat YES NO _____
- Heart YES NO _____
- Stomach, Bowel YES NO _____
- Respiratory (asthma, emphysema, COPD etc) YES NO _____
- Genital/Kidney HISTORY OF FLOMAX YES NO _____
- Skin YES NO _____
- Muscle, Joints, Bone YES NO _____
- Neurological (MS, stroke, etc) YES NO _____
- Psychiatric (depression, anxiety etc) YES NO _____
- Endocrine (diabetes, thyroid etc) YES NO _____
- Allergy/Immune System YES NO _____
- Blood/Lymph (cholesterol, anemia etc) YES NO _____
- Other _____

SURGICAL HISTORY

- ___ Cataract Surgery Right Left Both Date _____
- ___ Lasers Right Left Both Date _____
- LIST ANY OTHER SURGERIES:**
- _____ Date _____
- _____ Date _____
- _____ Date _____
- _____ Date _____
- _____ Date _____
- _____ Date _____

- UPDATED by:
Date/Tech/ MD (initials)
- _____/_____/_____ JTP BWC RJD _____
 - _____/_____/_____ JTP BWC RJD _____
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John T. Pajka, MD (JTP) Brian W. Chinavare, MD (BWC)

Robert J. Derick, MD (RJD)