Eye Surgeons of Indiana

MEDICAL HISTORY

Date: _____

Name: _____ DOB: _____ Age: _____

Phone: _____ Alt. Phone: _____ Sex: ☐ M ☐ F

Medical Doctor Name: _____

Contact Info: _____

Optometrist/Ophthalmologist: _____

Contact Info: _____

Check All That Apply

Cardiovascular	**Dates/Comments**
☐ Heart Disease/Surgery	
☐ Coronary Artery Disease	
☐ Stents	
☐ Bypass Surgery	
☐ Congestive Heart Failure	
☐ Irregular Heartbeat	
☐ Ablation	
☐ Pacemaker	
☐ Defibrillator	
☐ Valve Disease or Replacement	
☐ History of Chest Pain	
☐ Blood Thinners/Anticoagulant	
☐ Last EKG	
☐ Last Cardiology Visit	
☐ Hypertension	

Endocrine (Check all that apply)	**Dates/Comments**
☐ Thyroid	
☐ High Cholesterol	
☐ Diabetes	
☐ Insulin	
☐ Insulin Pump	

Pulmonary (Check all that apply)	**Dates/Comments**
☐ Chronic Obstructive Disease	
☐ Emphysema	
☐ Tuberculosis	
☐ Shortness of Breath	
☐ Asthma	
☐ CPAP/O_2	
☐ Sleep Apnea	

Check All That Apply

Renal/Kidney	**Dates/Comments**
☐ Renal Insufficiency/Stage _____	
☐ Dialysis	
☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S	
☐ Fistula ☐ R ☐ L	
☐ Kidney Stones	

Liver (Check all that apply)	**Dates/Comments**
☐ Hepatitis (Jaundice)	
☐ Cirrhosis	
☐ Failure	

Neurological (Check all that apply)	**Dates/Comments**
☐ Seizures/Epilepsy	
☐ Stroke/TIA	
☐ Migraine Headaches	
☐ Depression/Anxiety	
☐ Dementia	
☐ Parkinsons/Tremors	

General Health (Check all that apply)	**Dates/Comments**
☐ Recent Weight Gain	
☐ Osteoporosis	
☐ Cancer ☐ Current Port	
☐ AIDS	
☐ HIV	
☐ MRSA	
☐ CDIFF	
☐ Unable to lie flat for 30 minutes	
☐ Unable to walk w/o assistance	
☐ Walker ☐ Wheelchair	
☐ Hard of hearing	

Vital Signs: B/P: _____/_____ Pulse: _____ Height: _____ft _____in Weight: _____ lbs

List All Current Medications and Dosage (including OTC medications): ☐ None

Medication: _____ Dose: _____ | Medication: _____ Dose: _____
Medication: _____ Dose: _____ | Medication: _____ Dose: _____
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Medication: _____ Dose: _____ | Medication: _____ Dose: _____
Medication: _____ Dose: _____ | Medication: _____ Dose: _____
Medication: _____ Dose: _____ | Medication: _____ Dose: _____

Flu Vaccine: ☐ Yes ☐ No Date: _____

Pneumonia Vaccine: ☐ Yes ☐ No Date: _____

List Any Drug **Allergies & Reactions**: _____

_____

Latex Allergy: ☐ Yes ☐ No _____

Drug / Alcohol / Tobacco Use (circle), Details: _____

_____

Previous Surgeries (Approximate Dates): _____

_____

_____

Family Health History:

	Yes	No	Relationship
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Blood or Clotting Disorder	☐	☐	
Diabetes	☐	☐	
Cancer (Type):	☐	☐	

	Yes	No	Relationship
Cataracts	☐	☐	
Glaucoma	☐	☐	
Age Related Macular Degeneration	☐	☐	
Other	☐	☐	

Patient Signature: _____ **Date:** _____