Patty Vision Center Patient Medical History Form

Primary Care Physician:____

Patient Medical History

___ High Blood Pressure ____ Thyroid ___ Multiple Sclerosis

___ Diabetes ____ Heart Disease ___ Stroke

Please List Any Other Medical Problems You Have Been Diagnosed With:

____
____
____

Please List Any Medication You Are Currently Taking:

____
____
____

Please List Any Eye Medication You Are Currently Taking:

____

Please List Any Medication You Are Allergic To:

____

Smoking Status (Circle The One That Best Describes You)

Non Smoker Former Smoker Current Smoker
Current Everyday Smoker Current Sometimes Smoker Smokeless Tobacco User

Ocular Family History (Circle if Yes)

Glaucoma Retinal Problems Blindness
Other____

Ocular Surgery (Circle if Yes)

Cataract Surgery Glaucoma Surgery Laser Surgery Strabismus Surgery
Other ____

Review of System (Circle Any Problems You Are Currently Having)

Allergy
Hay Fever
Hives

Cardiovascular
Heart Pain
Palpations

Constitutional
Fever
Unexplained Weight Loss

Endocrine
Hormonal Problems
Diabetes
Thyroid Problems

Gastrointestinal
Nausea/Vomiting
Stomach Pain
Digestive Problem

Head/Neck
Headache
Neck Pain

Hematological
Anemia
Bleeding Problems

Immunological
HIV
Immunodeficiency

Skin
Rash

Musculoskeletal
Arthritis
Muscle Pain
Joint Pain

Neurological
Numbness or Tingling
Seizures

Psychiatric
Depression/Anxiety
Schizophrenia

Respiratory
Shortness of Breath
Wheezing

Primary Vision Insurance____
Primary Cardholder's Name____
Primary Cardholder's Date of Birth_______ - _______ - _______
Primary Cardholder's SSN_______-_______-_________

Primary Medical Insurance____
Primary Cardholder's Name____
Primary Cardholder's Date of Birth_______ - _______ - _______
Primary Cardholder's SSN_______-_______-_________