

Bloomberg Eye Center
MEDICAL HISTORY

Name: _____

ALLERGIES TO FOOD OR MEDICINE (STATE TYPE OF REACTION)

1. _____
2. _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY FOR ANY REASON INCLUDING EYE SURGERIES? PLEASE LIST.

DATE	REASON
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

HAVE YOU EVER HAD ANY OF THESE CONDITIONS?

		<u>Type, Date Diagnosed</u>
DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
ELEVATED CHOLESTEROL	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
EAR, NOSE, THROAT	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
BLOOD DISORDERS	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
THYROID	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
SKIN CONDITIONS	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
MUSCULOSKELETAL (ARTHRITIS, ETC.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
NEUROLOGIC / BRAIN (STROKE, SEIZURE, TUMOR, MS)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
LUNG OR BREATHING DISORDERS (ASTHMA, COPD)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

CARDIOVASCULAR YES NO _____
 (HEART ATTACK, BLOCKED ARTERY, ANEURYSM)
 GASTROINTESTINAL (ULCER, BOWEL DISEASE) YES NO _____
 GLAUCOMA YES NO _____
 CATARACTS YES NO _____
 OTHER EYE CONDITIONS YES NO _____
 CURRENTLY PREGNANT and/or NURSING YES NO _____

FAMILY HISTORY OF:

- DIABETES YES NO IF YES, WHO? _____
- GLAUCOMA YES NO IF YES, WHO? _____

WHO IS YOUR FAMILY PHYSICIAN? _____ LAST SEEN: / /

WHO IS YOUR OPTOMETRIST? _____ LAST SEEN: / /

Medications / Eye Drops

NAME	DOSAGE	# TIMES A DAY
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		

HAVE YOU EVER USED ALCOHOL? YES NO
 IF YES, HOW OFTEN AND HOW MUCH? _____

HAVE YOU EVER USED TOBACCO IN ANY FORM? YES NO
 IF YES, HOW MUCH AND FOR HOW LONG? _____

PLEASE NOTE ANY OTHER CONDITIONS: _____