SightMD New Jersey

MEDICAL HISTORY FORM

NAME _____ **AGE** _____ **DATE** _____

REFERRING DOCTOR OR PERSON _____

EYE HISTORY: Do You Wear Glasses _____ Contact Lenses _____ Date of Last Eye Exam _____

EYE PROBLEMS: Please Check any of the following problems that you have.

___ Blurred or Poor Vision
___ Trouble Reading Signs
___ Poor Depth Perception
___ Trouble Identifying Colors
___ Double vision
___ Poor Night Vision
___ Glare From Lights
___ Halos Around Lights
___ See Spots or Floaters
___ See Light Flashes
___ Gritty Sensation
___ Tearing
___ Itching or Burning
___ Eye Pain
___ Redness or bloodshot

___ **OTHER** _____

PLEASE MARK ANY CONDITION YOU OR A BLOOD RELATIVE HAVE. INDICATE RELATIONSHIP.

YOU	RELATIVE		YOU	RELATIVE	
___	_____	Dry Eyes	___	_____	Macular Degeneration
___	_____	Glaucoma	___	_____	Retinal Detachment
___	_____	Cataracts	___	_____	OTHER
			___	_____	**CHECK IF NONE**

HAVE YOU EVER HAD EYE SURGERY (including laser)? ___ **YES** ___ **NO**

If Yes, describe & give dates: _____

EYE MEDICATIONS: Please List: _____

DRUG ALLERGIES: __ NONE or **Please List:**
_____

MEDICAL HISTORY: **Medical Doctor** _____ **Location** _____ **Phone #** _____

Please mark any condition you or a blood relative have/indicate relationship: **CHECK HERE IF NONE** _____

YOU	RELATIVE		YOU	RELATIVE	
___	_____	High Blood Pressure	____	_____	Heart Problems (Arrhythmia, Angina, Congestive Heart Failure)
___	_____	Diabetes			
___	_____	Stroke	____	_____	Lung Problems (Sarcoidosis, Emphysema, COPD, Asthma)
___	_____	Arthritis			
___	_____	Ulcers	____	_____	Thyroid Problems
___	_____	Others: PLEASE LIST _____			

LIST ALL MEDICINES: INCLUDE DOSAGE (i.e. mg) & HOW MANY TIMES TAKEN DAILY.

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List any non-ocular surgery and date:-_____

SOCIAL HISTORY: **Smoke** __ NO ___ YES (Cigarettes, Cigars, Pipe) _____# per day. List any drugs: _____
Alcohol __ NO ___YES (Beer, Wine, Liquor) ____ Social or Indicate Daily Consumption _____

REVIEW OF SYSTEMS: (Circle or list problems you have in any area) **CHECK HERE IF NONE: _____**

CONSTITUTIONAL & INTEGUMENTARY: Fever, Weight Loss, Rash, Skin Disease _____

HEAD/NECK: Sinus Problems, Post–Nasel Drip, Runny Nose, Dry Mouth, Hearing Loss _____

RESPIRATORY: Cough, Bronchitis, Shortness of Breath, Asthma, Emphysema, COPD _____

CARDIOVASCULAR: Chest Pain, Congestive heart Failure, Irregular Rhythm _____

GASTROINTESTINAL: Vomiting, Ulcers, Diarrhea, Bloody Stools _____

GENITOURINARY: Genital Ulcers, Discharge, Kidney Stones, Blood in Urine _____

ALLERGIC/IMMUNOLOGIC & BLOOD/LYMPHATIC: Seasonal allergies, Hay Fever, _____

Neurologic, Neurologic, Psychiatric & Musculoskeletal: Headache, Migranes, Paralysis, Joint aches _____