metro eye MD

PATIENT HISTORY

Name:_____

Medications you take (including oral contraceptives and over the counter):		
Are you allergic to any medications?	**Yes**	**No**
Are you currently being treated for any medical condition?	**Yes**	**No**
If yes, explain:		
Are you pregnant or nursing?	**Yes**	**No**
Do you smoke? (If so how much)	**Yes**	**No**

	Yes	No
Chronic fever, unexpected weight loss, fatigue	☐	☐
Ear, nose, throat problems, sinusitis, hearing loss	☐	☐
Heart problems, chest pain, irregular heart beat	☐	☐
Respiratory problems, wheezing, cough, shortness of breath	☐	☐
Gastrointestinal problems, diarrhea, vomiting, heartburn, pain	☐	☐
Urinary problems, pain, discharge, blood in urine, urgency	☐	☐
Skin problems, acne, seborrhea, eczema, psoriasis, rashes	☐	☐
Musculoskeletal problems, aching, joint pain, joint swelling	☐	☐
Neurologic symptoms, numbness, weakness, headaches	☐	☐
Psychiatric problems, depression, anxiety, agitation	☐	☐

Eye Conditions	**Yes**	**No**	**General Health Conditions**	**Yes**	**No**
Glaucoma			Diabetes		
Cataracts			High Blood Pressure		
Retinal Detachment/Retinal Problem			Heart Disease		
Lazy Eye/Amblyopia			Breathing Problems		
Eye Surgery			Auto-Immune Disease		
Dry Eye			Arthritis		
Eye Injury/Infection			Seasonal Allergies		
Other (list):			Other (list):		

Eye History

When was your last eye exam?	**Doctors Name/City:**	
How old are your present glasses?	**Do you wear contacts? Yes No**	**How old are your contacts?**

When do you use glasses/contacts? **Constantly** **Reading Only** **Distance Only** **Rarely**

Notes and items you think we should know about, not listed or described above: