MEDICAL HISTORY-PAGE 1

Patient Name_______________________________________ **Date of Birth**___/___/____ **Today's Date**___/___/___

Who is your medical doctor?______________________________ ☐ M.D. ☐ D.O. **Last medical exam**___/___/___
Dr. Address____ ________**Phone**______-______-_______
Street City/State/Zip
Pharmacy Name________________ **Address**________________________________ **Phone**______-______-______

Reason for visit today:____
What eye problems have you had in the past? ☐ None **Last eye exam**___/___/___
☐ Cataracts ☐ Macular Degeneration ☐ Glaucoma ☐ Diabetic Retinopathy ☐ Vision Loss
☐ Dry eye ☐ Lazy/Crossed eyes ☐ Flashes/Floaters ☐ Double vision ☐ Retinal Detachment
☐ Cataract surgery: Right eye (date)___/___/___ Left eye (date)___/___/___
☐ Retinal surgery Right eye (date)___/___/___ Left eye (date)___/___/___
☐ Lasik surgery Right eye (date)___/___/___ Left eye (date)___/___/___

Other eye surgeries, infections, injuries, diseases, conditions: ____

Current Eye Medications (including prescription, over-the-counter, artificial tears, eye vitamins) ☐ None

Medication & Dosage	**for treatment of**	**Medication & Dosage**	**for treatment of**
1.______________________	____________________	3.___________________	____________________
2.______________________	____________________	4.___________________	____________________

Eyeglasses: ☐ None ☐ Single Vision (distance or reading- circle) ☐ Bifocal ☐ Trifocal ☐ Progressive
How old is your current pair of glasses? ___________________________
Contact Lenses: ☐ None ☐ Single Vision ☐ Multifocal

	Right Eye	Left Eye
Brand	________________________________	_________________________________
Base Curve (B.C.)	________________________________	_________________________________
Diameter	________________________________	_________________________________
Power	________________________________	_________________________________

How often do you replace your contact lenses?____
What disinfecting solution do you use?____
How many hours per day do you wear your contact lenses?____
Do you sleep in your contact lenses?_______________ If yes, how many consecutive nights?_____________

Do you have any allergies? ☐ None ☐ Penicillin ☐ Sulfa ☐ Fluorescein ☐ Seasonal
☐ Iodine ☐ Shellfish ☐ Latex ☐ Other_____________________________________

Current Medications (including aspirin, contraceptives, over-the counter, vitamins) ☐ None

Medication & Dosage	**for treatment of**	**Medication & Dosage**	**for treatment of**
1._____________________	___________________	4._____________________	______________________
2._____________________	___________________	5. _____________________	______________________
3._____________________	___________________	6._____________________	______________________

(Attach list of medications and dosages if necessary)
List past surgeries:____
Are you pregnant/nursing? ☐ Yes ☐ No
Signature of Patient/Parent or Guardian____**Date**______________

MEDICAL HISTORY-PAGE 2

Social History

Do you use tobacco? ☐ No ☐ Previously ☐ Cigarettes ☐ Cigars ☐ Smokeless **#/ day:___ How many years?___**

Do you drink alcohol? ☐ No ☐ Previously ☐ Yes **Amount :_______________ per day/week/month. (circle one)**

Past and present drug use (legal or illegal) is important for drug and anesthetic interactions. Please indicate if we need to be aware of this. ☐ Yes ☐ No

Have you had a blood transfusion since 1977? ☐ Yes ☐ No **When?____________________**

Have you ever been exposed to or infected with Gonorrhea? ☐ Yes ☐ No **Syphilis?** ☐ Yes ☐ No

Family Eye History

Have any members of your family had any of the following eye problems? Please check all that apply.

☐ I do not know my family eye history.

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cataract								
Glaucoma								
Diabetic Retinopathy								
Macular Degeneration								
Retinal Detachment								
Crossed/Lazy Eyes								

Any other significant family eye history?____

____

Family Medical History

Have any members of your family had any of the following conditions? Please check all that apply.

☐ I do not know my family medical history.

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Thyroid Disease								
Cancer (Specify)								

Any other significant family medical history?____

____

Your eyes will be dilated for your exam. Dilation will make the pupils of your eyes large for several hours and can cause light sensitivity, glare and blurred vision. Dark glasses are required. If you do not have your own, please ask us for a pair.

Signature of Patient/Parent or Guardian____Date______________

MY MEDICAL HISTORY-PAGE 3

Please check "Yes" for any problems you have experienced and explain. Check "No" if you have not had any problem.

Allergic/Immunologic
- ☐ Yes ☐ No Lupus____
- ☐ Yes ☐ No Lyme Disease__________________________________
- ☐ Yes ☐ No Rheumatoid Arthritis___________________________
- ☐ Yes ☐ No HIV____
- ☐ Yes ☐ No Sarcoidosis___________________________________
- ☐ Yes ☐ No Other_______________________________________

Heart and Blood Vessels (Cardiovascular)
- ☐ Yes ☐ No Heart attack__________________________________
- ☐ Yes ☐ No High blood pressure______How many yrs.?_______
  Last blood pressure__________________________
- ☐ Yes ☐ No Cholesterol___________________________________
- ☐ Yes ☐ No Heart murmur_________________________________
- ☐ Yes ☐ No Irregular heart beat___________________________
- ☐ Yes ☐ No Mitral valve prolapse__________________________
- ☐ Yes ☐ No Chest pain____________________________________
- ☐ Yes ☐ No Circulation problems__________________________
- ☐ Yes ☐ No Other_______________________________________

General (Constitutional)
- ☐ Yes ☐ No Weight loss/Weight gain (circle one)____________
- ☐ Yes ☐ No Fever_______________________________________
- ☐ Yes ☐ No Lack of energy_________________________________
- ☐ Yes ☐ No Trouble sleeping______________________________
- ☐ Yes ☐ No Other_______________________________________

Endocrine
- ☐ Yes ☐ No Diabetes_____________________________________
  When diagnosed?___________________________________
  Are you on insulin?___________ X per day______________
  What is your Hgb A1C?______________________________
  Recent range: From_______________ to________________
  Do you test at home?_______________________________
  Are you on kidney dialysis?__________________________
- ☐ Yes ☐ No Thyroid condition Hyper/Hypo (circle one)_______
- ☐ Yes ☐ No Other_______________________________________

Stomach & Intestines (Gastrointestinal)
- ☐ Yes ☐ No Ulcers______________________________________
- ☐ Yes ☐ No Diverticulitis__________________________________
- ☐ Yes ☐ No Constipation/Diarrhea__________________________
- ☐ Yes ☐ No Crohn's Disease_______________________________
- ☐ Yes ☐ No Liver disorder_________________________________
- ☐ Yes ☐ No Other_______________________________________

Kidney, Bladder, Prostate (Genitourinary)
- ☐ Yes ☐ No Kidney disorder_______________________________
- ☐ Yes ☐ No Urinary infections______________________________
- ☐ Yes ☐ No Excessive/Difficult urination___________________
- ☐ Yes ☐ No Cancer_______________________________________
- ☐ Yes ☐ No Prostate Enlargement_________________________
- ☐ Yes ☐ No Other_______________________________________

Ears, Nose, Mouth, Throat
- ☐ Yes ☐ No Hearing loss__________________________________
- ☐ Yes ☐ No Chronic sinus problem__________________________
- ☐ Yes ☐ No Infections_____________________________________
- ☐ Yes ☐ No Vertigo/lightheadedness________________________
- ☐ Yes ☐ No Other_______________________________________

Blood (Hematologic/Lymphatic)
- ☐ Yes ☐ No Anemia (low blood count)______________________
- ☐ Yes ☐ No Excessive bleeding_____________________________
- ☐ Yes ☐ No Bruising easily________________________________
- ☐ Yes ☐ No Clotting problems_____________________________
- ☐ Yes ☐ No Hodgkin's Disease_____________________________
- ☐ Yes ☐ No Leukemia_____________________________________
- ☐ Yes ☐ No Other_______________________________________

Skin/Breast (Integumentary)
- ☐ Yes ☐ No Rashes, sensitivities___________________________
- ☐ Yes ☐ No Rosacea______________________________________
- ☐ Yes ☐ No Skin cancer____________________________________
- ☐ Yes ☐ No Keloid (aggressive) scarring_____________________
- ☐ Yes ☐ No Breast cancer__________________________________
- ☐ Yes ☐ No Other_______________________________________

Bones, Joints, Muscles (Musculoskeletal)
- ☐ Yes ☐ No Osteoporosis__________________________________
- ☐ Yes ☐ No Arthritis______________________________________
- ☐ Yes ☐ No Chronic Muscle/Joint pain______________________
- ☐ Yes ☐ No Other_______________________________________

Nervous System & Brain (Neurological)
- ☐ Yes ☐ No Seizure______________________________________
- ☐ Yes ☐ No Stroke_______________________________________
- ☐ Yes ☐ No Bell's Palsy____________________________________
- ☐ Yes ☐ No Multiple Sclerosis_______________________________
- ☐ Yes ☐ No Parkinson's Disease_____________________________
- ☐ Yes ☐ No Myasthenia Gravis (extreme muscle weakness)____
- ☐ Yes ☐ No Neuralgia (intense pain along nerve)_____________
- ☐ Yes ☐ No Paralysis/weakness_____________________________
- ☐ Yes ☐ No Numbness_____________________________________
- ☐ Yes ☐ No Migraines_____________________________________
- ☐ Yes ☐ No Other_______________________________________

Mental Illness (Psychiatric)
- ☐ Yes ☐ No Depression____________________________________
- ☐ Yes ☐ No Anxiety_______________________________________
- ☐ Yes ☐ No Mania/bipolar__________________________________
- ☐ Yes ☐ No Schizophrenia__________________________________
- ☐ Yes ☐ No Psychosis______________________________________
- ☐ Yes ☐ No Other_______________________________________

Lungs (Respiratory)
- ☐ Yes ☐ No Asthma_______________________________________
- ☐ Yes ☐ No Bronchitis_____________________________________
- ☐ Yes ☐ No Shortness of breath_____________________________
- ☐ Yes ☐ No Emphysema____________________________________
- ☐ Yes ☐ No Tuberculosis___________________________________
- ☐ Yes ☐ No Other_______________________________________

I am aware that it is my responsibility to notify the office of Christopher J. Nowik, OD, PC of any changes to the information on this Medical History form.

Signature of Patient/Parent or Guardian____ Date________________________