TENNESSEE EYE CARE

PATIENT MEDICAL HISTORY

PATIENT: _____ DOB: _____

EYE HEALTH

Have you ever had problems in the following areas?

Cataracts	Yes ☐	No ☐
Diabetic Retinopathy	Yes ☐	No ☐
Eye Injury	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐
Lazy Eye/Eye Turning	Yes ☐	No ☐
Macular Disease	Yes ☐	No ☐
Retinal Detachment	Yes ☐	No ☐
Wearing Contact Lenses	Yes ☐	No ☐

HAVE YOU HAD A RECENT FLU OR PNEUMONIA SHOT?

Flu:	Yes ☐	No ☐
Pneumonia:	Yes ☐	No ☐

PAST MEDICAL HISTORY

Have you ever had problems in the following areas?

AIDS/HIV	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Bronchitis	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
COPD	Yes ☐	No ☐
Defibrillator	Yes ☐	No ☐
Depression	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Fainting Spells	Yes ☐	No ☐
Hay Fever	Yes ☐	No ☐
Headaches	Yes ☐	No ☐
Heart Problems	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐

High Blood Pressure	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐
Kidney Stones	Yes ☐	No ☐
Low Blood Pressure	Yes ☐	No ☐
Lupus	Yes ☐	No ☐
Migraines	Yes ☐	No ☐
MRSA	Yes ☐	No ☐
Multiple Sclerosis	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐
Rosacea	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Shingles	Yes ☐	No ☐
Sleep Apnea	Yes ☐	No ☐
Slow Heart Rate	Yes ☐	No ☐
Staph Infection	Yes ☐	No ☐

FAMILY HISTORY

Have any blood relatives had problems in any of the following areas?

Blindness	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐
Macular Disease	Yes ☐	No ☐
Migraine	Yes ☐	No ☐

SOCIAL HISTORY

Do you drink alcohol?	Yes ☐	No ☐
Do you smoke?	Yes ☐	No ☐
Ever smoked?	Yes ☐	No ☐
Are you pregnant?	Yes ☐	No ☐
Are you nursing?	Yes ☐	No ☐

REVIEW OF BODY SYSTEMS

Have you ever had problems in the following areas?

Bones, Muscles, Joints	Yes ☐	No ☐
Digestion or Stomach	Yes ☐	No ☐
Ears, Nose, Throat	Yes ☐	No ☐
Heart or Blood	Yes ☐	No ☐
Kidney or Bladder	Yes ☐	No ☐
Lungs	Yes ☐	No ☐
Neck	Yes ☐	No ☐
Nerves	Yes ☐	No ☐
Skin	Yes ☐	No ☐

PLEASE LIST ALL PREVIOUS SURGERIES:

_____
_____
_____
_____

ALLERGY TO MEDICINES (please list):

_____
_____
_____
_____

PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDING EYEDROPS):

_____
_____
_____
_____

Office Use Only

Int____ Date____ Int____ Date____ Int____ Date____ Int____ Date____ Int____ Date____