MR # __________

Hollingshead Eye Center, P.C.℠

## HOLLINGSHEAD EYE CENTER - GENERAL MEDICAL HISTORY

**Name:** ______________________ **Date of birth:** ____________ **Today's Date:** ____________

**Age:** ______ **Height:** _______ **Weight:** _______ **Sex:** ☐ M ☐ F **Pharmacy:** ____________________

**Primary care physician:** ________________________ **Optometrist:** ________________________

**PERSONAL MEDICAL HISTORY – Please mark if you have ever been diagnosed with or are being treated with medications for the following medical conditions:**

- ☐ Asthma
- ☐ Arthritis
- ☐ Back / Neck Problems
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Cancer: ________________
- ☐ Chest pain / Angina
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression / Anxiety
- ☐ Diabetes (type) ______
- ☐ Emphysema
- ☐ ENT Problems
- ☐ GI Problems
- ☐ HIV / AIDS
- ☐ Hard of Hearing
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis: Type _______
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney / Bladder Problems
- ☐ Liver Disease
- ☐ Malignant hyperthermia
- ☐ Multiple Sclerosis
- ☐ MRSA / VRE
- ☐ Osteoporosis
- ☐ Psychiatric Problems
- ☐ Pacemaker
- ☐ Palpitations
- ☐ Prostate Problems
- ☐ Restless Leg Syndrome
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke / CVA / TIA
- ☐ Syphilis / Gonorrhea
- ☐ Urinary / Gynecological Problem
- ☐ **NONE**
- ☐ OTHER ________________________________________________

**ADDITIONAL OPHTHALMIC RELATED MEDICAL HISTORY – Please mark if you have ever been diagnosed with or are being treated with medications for the following medical conditions:**

- ☐ Ankylosing Spondylitis
- ☐ Behcet's Disease
- ☐ Blepharitis
- ☐ Cataract
- ☐ Crohn's Disease
- ☐ Corneal Scarring
- ☐ Dry Eye Syndrome
- ☐ Glaucoma
- ☐ Grave's Disease
- ☐ Herpes Simplex (Cold Sores)
- ☐ Herpes Zoster (Shingles)
- ☐ Keloid Disorder
- ☐ Keratoconus
- ☐ Lupus
- ☐ Meibomian Gland Dysfunction
- ☐ Retina Problems
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis
- ☐ Other Autoimmune Disease ___

________________________________________________

**Date of last flare up:** ____________

**Previous Eye Surgery or Injury?** ☐ Yes ☐ No (Please list any previous eye surgeries, lasers, injections, injuries, or other treatments and approximate dates)

________________________________________________

**Please list all eye drops or eye medications you are currently using. Include frequency and which eye:**

________________________________________________

**Do you wear any of the following:** ☐ **Glasses (distance)** ☐ **Glasses (readers)** ☐ **Contact lenses:** ____________ **(type)**

Patient Name:______________________________ Date of Birth:____________ 

**SOCIAL HISTORY:**

Do you drink alcohol? ☐Yes ☐No Drinks per week? ________

Do you smoke? ☐Yes ☐No Packs per Day? _________ How many years? _________ Former smoker? ☐Yes ☐No

Occupation: ____________________________________

**FAMILY HISTORY:** (Please mark any that apply below and indicate your relationship)

| | | |
|---|---|---|
| ☐ Arthritis _____________ | ☐ Glaucoma ______________ | ☐ Melanoma _____________ |
| ☐ Blindness _____________ | ☐ Hypertension ____________ | ☐ Thyriod ______________ |
| ☐ Cataract _____________ | ☐ Keratoconus ______________ | ☐ Stroke ______________ |
| ☐ Cancer _____________ | ☐ Macular Degeneration _____________ | ☐ Other ______________ |

**SURGICAL HISTORY**: Please list **all** prior surgeries within the past 10 years to the best recollection, include approximate dates:

| Procedure | Date |
|---|---|
| | |
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| ALLERGIES (medication, food, latex & adhesives) | |
|---|---|
| ☐ NONE | |
| **Allergy** | **Reaction** |
| | |
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| | |
| | |

**Complications with previous anesthesia / sedation?**

☐ NO ☐ YES:_________________________________

| Please attach, or list all current Medications (include prescription and over the counter meds) | | | |
|---|---|---|---|
| ☐ NONE | | | |
| **Medication Name** | **Dose** | **Times per day** | **Reason** |
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**Are you taking a blood thinner?** ☐ **NO** ☐ **YES:** ______________________________________________

(Aspirin, Coumadin / Warfarin, Eliquis, Plavix, Xarelto, Pradaxa)

**Are you on Oxygen?** ☐ **NO** ☐ **YES:** ____________ **liters** **Reason:** ______________________________

**Do you have mobility restrictions?** ☐ **NO** ☐ **YES - Do you use the following?** ☐ **Walker** ☐ **Wheelchair**

**Are you able to lay on your back for a time period of at least 20 minutes or longer?** ☐ **YES** ☐ **NO:** _________
(reason)

__________________________________________ __________________

**Patient Signature** **Date**

**Reviewed By:** __________

Patient name:______________________________ Date of Birth:_______________ 

**Additional Prescribed Medications**

| Medication Name | Dose | Times per day | Reason |
|---|---|---|---|
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Patient Signature Date