Monadnock Eye Physicians and Surgeons
MEDICAL HISTORY

Patient's name:_____ **Date:**_____

Please answer the following questions about your medical status and history:

1. Do you have any **medical conditions** (diabetes, heart disease, arthritis, sexually transmitted disease)?

2. Do you have a history of any **eye problems** (injury, lazy eye, glaucoma, macular degeneration, retinal detachment, etc.)?

3. Have you had any **surgery** (including eye surgery)?

4. List any **hospitalizations** in the last 6 months and the associated conditions

5. List all the **medications** that you take, including eye drops and non-prescription products

6. List any drug **allergies** and describe the reaction

7. Do any eye or medical diseases run in your **family** (macular degeneration, glaucoma, diabetes, heart disease, cancer)?

SOCIAL HISTORY

Do you **smoke**? Y N How much _____ Do you have help at home if needed? Y N

Do you drink **alcohol**? Y N How much_____ Education level_____

Do you **drive**? Y N Do you live alone? Y N Occupation_____

Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other_____

REVIEW OF SYSTEMS Do you currently have any of the following problems? Please explain.

Chronic fever, unexpected weigh loss/gain, fatigue_____

Neurologic problems (headache, weakness, numbness)_____

Musculoskeletal problems (muscle ache, joint pain)_____

Skin problems (rashes, excessive dryness)_____

Ear, nose, throat problems (hearing loss, sinus problems, sore throat)_____

Heart problems (chest pain, irregular heart beat)_____

Respiratory problems (shortness of breath, cough)_____

Gastrointestinal problems (diarrhea, vomiting)_____

Urinary problems (pain, blood in urine)_____

Psychiatric problems (depression, anxiety)_____

MD Review and Date