Midwest Eye Professionals

Confidential Patient History

Patient Name: _____ Appointment Date:_____

Are you currently under the care of a medical Physician? Yes No Last Visit:_____

Describe your health: Good____ Fair____ Poor____ Recent changes? Yes____ No_____

List all major surgeries/hospitalizations and what year: _____

_____

List all medications, including aspirin and over the counter medications that you are currently taking:

_____

List all allergies: _____

Have you ever had?	**YES**	**NO**	**Have you ever had?**	**YES**	**NO**
Diabetes			Ear/Nose/Mouth or Throat Problems		
How Long? Controlled?			History of Stroke		
High Blood Pressure			Loss of Consciousness		
How Long? Controlled?			History of Seizure or Epilepsy		
Heart Problems			Emotional Disorder		
Asthma or Emphysema			Severe Skin Problems		
History of Tuberculosis			Thyroid Disease		
Kidney Problems			Stomach/ Intestinal Problems		
Are you on Dialysis?			Liver Disease		
Blood-related Conditions			Enlarged / Tender Lymph Nodes		
Sickle-Cell Disease			Arthritis or Joint Pain		
Weakened Immune System			Lupus		
Migraine Headaches			History of Venereal Disease		
Cholesterol			History of Cancer		

Do you have:	**YES**	**NO**	**Do you have:**	**YES**	**NO**
Recent Fevers			Skin Rash		
Difficulty Swallowing			Dizziness or Blackouts		
Chest Pain			Feelings of Depression		
Ringing in the Ears			Unexplained Weight Loss		
Shortness of Breath			Swollen Lymph Glands		
Stomach / Abdominal Pain			Feelings of Weakness		
Frequent / Painful Urination			Highly Allergic		
Frequent Headaches			Susceptible to Infections		

Do you smoke? Yes ____ No ____ Year Quit? _____

Do you drink alcohol? Yes ____ No ____ How Much? _____ **(OVER)**

Have you ever had?	Y	N	Have you ever had?	Y	N	Have you ever had?	Y	N
Amblyopia / Lazy Eye			Dry Eyes			Diabetic Retinopathy		
Cataracts			Loss of Vision			Heredity Eye Disease		
Flashes in Vision			Glaucoma			Macular Degeneration		
Floaters in Vision			Retinal Detachment			Other:		

Do you wear glasses? Yes ____ No ____ Do you wear contact lenses? Yes ____ No ____

When was your last eye exam? _____ Doctor's Name: _____

List all previous eye surgeries or procedures: _____

_____

List all eye drops and eye medications: _____

_____

Family History

Do any of your blood relatives, living or deceased, have any of the following conditions?

Condition	Relative/Status	Condition	Relative/Status
Diabetes		Diabetic Retinopathy	
High Blood Pressure		Glaucoma	
Heart Disease		Macular Degeneration	
Kidney Disease		Retinal Detachment	
Migraine Headaches		Hereditary Eye Disease	
Stroke		Cancer	

I have reviewed and updated the information on this form. My signature validates that all information is current and complete:

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____