Lakeland Eye Clinic
*Care You Can See*

# MEDICAL HISTORY

NAME

BIRTH DATE

CHART #

REFERRING PHYSICIAN (if any)

TODAY'S DATE

OCCUPATION

FORMER OCCUPATION (if retired)

MARITAL STATUS
○ Single ○ Married ○ Divorced ○ Widowed

Do you drink alcohol?
○ Yes ○ No

Do you smoke?
○ Yes ○ No

Do you drive?
○ Yes ○ No

Are you allergic to any medications?
○ Yes ○ No

Surgeries / Hospitalizations within the last year:

# QUESTIONARE

Please check yes or no. DO NOT LEAVE ANYTHING BLANK.

| YES | NO | EYES |
|---|---|---|
| | | Cataract |
| | | Glaucoma |
| | | Macular Degeneration |
| | | Retinal Detachment |
| | | Lazy Eye |
| | | Laser Treatment |
| | | Prior Eye Surgery |
| | | Other Eye Conditions: |

| YES | NO | OTHER MEDICAL |
|---|---|---|
| ○ | ○ | Diabetes |
| ○ | ○ | Cancer |
| ○ | ○ | Heart Disease or Stroke |
| ○ | ○ | High Blood Pressure |
| ○ | ○ | Asthma |
| ○ | ○ | Chronic Bronchitis / Emphysema |
| ○ | ○ | Arthritis |
| ○ | ○ | Thryoid Disease |
| ○ | ○ | History of Blood Transfusion |

| YES | NO | REVIEW OF SYSTEMS |
|---|---|---|
| ○ | ○ | General: Fever |
| ○ | ○ | Weight Loss |
| ○ | ○ | Ear, Nose, Throat: Dry Mouth |
| ○ | ○ | Heart / Vessels: Chest Pain |
| ○ | ○ | Palpitations |
| ○ | ○ | Lungs: Shortness of Breath |
| ○ | ○ | Skin: Rash |
| ○ | ○ | Digestive: Nausea / Vomiting |
| ○ | ○ | Urinary: Blood in Urine |
| ○ | ○ | Musculoskeletal: Joint Pain |
| ○ | ○ | Neurologic: Headache |
| ○ | ○ | Emotional: Depressed Mood |

M=Mother / F=Father / S=Sibling / GP= Grandparent

| YES | NO | FAMILY HISTORY | RELATIONSHIP |
|---|---|---|---|
| ○ | ○ | Blindness | ○M ○F ○S ○GP |
| ○ | ○ | Glaucoma | ○M ○F ○S ○GP |
| ○ | ○ | Diabetes | ○M ○F ○S ○GP |
| ○ | ○ | Heart Disease | ○M ○F ○S ○GP |
| ○ | ○ | Arthritis | ○M ○F ○S ○GP |
| ○ | ○ | Other: | |

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**FOR OFFICE USE ONLY. DO NOT FILL OUT BELOW.**

PHYSICIAN'S SIGNATURE _____ DATE _____ REFERENCE BY _____

| DATE | SIGNATURE | CHANGES |
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| DATE | SIGNATURE | CHANGES |
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| DATE | OCULAR DIAGNOSIS & SURGERIES | MEDICATIONS |
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| | DATE | DATE | DATE | DATE | DATE | DATE | MEDICAL DIAGNOSIS |
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| GONIO | | | | | | | DM HTN ASTHMA HEART DZ |
| VF | | | | | | | |
| HRT | | | | | | | |
| DFE | | | | | | | |
| ON PHOTO | | | | | | | |
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