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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PHYSICIAN'S SIGNATURE _____ DATE _____ REFERENCE BY _____

DATE	SIGNATURE	CHANGES

DATE	SIGNATURE	CHANGES

DATE	OCULAR DIAGNOSIS & SURGERIES	MEDICATIONS

	DATE	DATE	DATE	DATE	DATE	DATE	MEDICAL DIAGNOSIS
GONIO							DM HTN ASTHMA HEART DZ
VF							
HRT							
DFE							
ON PHOTO							