MULLIS EYE INSTITUTE

MEDICAL HISTORY/REVIEW OF SYSTEMS

Today's Date_____

Pt. Name_____

Height _____ft_____in Weight_____lbs

RACE: ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other

Name of Referring Physician_____

Name of Primary Care Doctor_____

City & Phone #_____

Date of Last Check Up _____/_____/_____

Your Pharmacy_____

City & Phone _____ _____

OCULAR HISTORY:	YES	NO
CATARACTS	☐	☐
CATARACT SURGERY YEAR_____		
LEFT ☐ RIGHT ☐ BOTH ☐		
RETINAL DISEASE	☐	☐
CORNEAL DISEASE	☐	☐
CROSSED EYES/LAZY EYE	☐	☐

	YES	NO
IRITIS	☐	☐
GLAUCOMA	☐	☐
REFRACTIVE/LASIK SURGERY	☐	☐
EYELID SURGERY	☐	☐
EYE INJURY	☐	☐

GENERAL:	YES	NO
DO YOU SMOKE?	☐	☐
HAVE YOU EVER SMOKED?	☐	☐
HOW LONG?_____/YRS PACKS _____DAY		
CONSUME ALCOHOL?	☐	☐
IF SO HOW MUCH/OFTEN?_____		
DO YOU WEAR DENTURES?	☐	☐
DO YOU WEAR HEARING AIDS?	☐	☐

	YES	NO
DO YOU LIVE IN A NURSING HOME?	☐	☐
WHEEL CHAIR?	☐	☐
ABLE TO TRANSFER?	☐	☐
FOR WOMEN: ARE YOU PREGNANT?	☐	☐
CANCER	☐	☐
IF YES, WHERE?_____		

FAMILY HISTORY: (**F**=FATHER **M**=MOTHER **S**=SISTER **B**=BROTHER **GF**=GRANDFATHER **GM**=GRANDMOTHER **U**=UNCLE **A**=AUNT)

	YES	NO
GLAUCOMA……	☐	☐
CATARACTS……	☐	☐
CORNEAL DISEASE……..	☐	☐
MACULAR DEGENERATION……...	☐	☐
DIABETIC RETINOPATHY……	☐	☐
RETINAL DETACHMENT……..	☐	☐

	YES	NO
RETINITIS PIGMENTOSA……	☐	☐
CANCER……..	☐	☐
DIABETES……...	☐	☐
HEART CONDITIONS……...	☐	☐
STROKE……	☐	☐

Medications: *list all prescriptions, over the counter, herbal and vitamin/mineral/dietary supplements*

Name of Medication	Doseage	Frequency	Administered Route
Example: Aspirin	80mg	1 in am	Oral (By Mouth)

SURGICAL HISTORY: List all surgeries including date: Any problems with Anesthesia in the past? ☐ YES ☐ NO

Surgery	Date	Complications	Problems with Anesthesia?

LIST ALL ALLERGIES TO FOODS AND MEDICATIONS:_____

For office use only

Date___/___/___ Tech_____ Dr. Sign_____ Date___/___/___ CRNA_____

Date___/___/___ Tech_____ Dr. Sign_____ Date___/___/___ CRNA_____

Date___/___/___ Tech_____ Dr. Sign_____ Date___/___/___ CRNA_____

ENDOCRINE:	**YES**	**NO**		**YES**	**NO**
INCREASED URINATION/THIRST….....	☐	☐	DIABETES……	☐	☐
LOW BLOOD PRESSURE…….....	☐	☐	TYPE I ☐ TYPE II ☐ YEAR OF DIAGNOSIS_____		
UNEXPLAINED WEIGHT LOSS/GAIN…..	☐	☐	CONTROLLED BY:		
THYROID PROBLEMS……	☐	☐	☐ ORAL MEDS ☐ INJECTION		

RESPIRATORY:	**YES**	**NO**		**YES**	**NO**
CHRONIC COUGH…….....	☐	☐	LUNG PROBLEMS/ASTHMA/TB……	☐	☐
WHEEZING/SHORT OF BREATH……	☐	☐	COPD/EMPHYSEMA…….....	☐	☐
SLEEP APNEA……..	☐	☐	HOME OXYGEN USE……	☐	☐
WEAR C-PAP……	☐	☐	BRONCHITIS/PNEUMONIA…….....	☐	☐

CARDIOVASCULAR:	**YES**	**NO**		**YES**	**NO**
BLOOD CLOTS……..	☐	☐	MURMUR/PALPITATIONS/VALVE DISEASE….	☐	☐
CHEST PAIN/ANGINA……..	☐	☐	HIGH BLOOD PRESSURE……	☐	☐
CONGESTIVE HEART FAILURE….	☐	☐	SHORTNESS OF BREATH……...	☐	☐
ATRIAL FIB/ARRHYTHMIA……...	☐	☐	HIGH CHOLESTEROL……	☐	☐
HEART CATH/STENTS……..	☐	☐	HEART ATTACK……..	☐	☐
IF YES, WHEN_____/_____/_____			IF YES, WHEN_____/_____/_____		
STRESS TEST……	☐	☐	BYPASS/OPEN HEART SURGERY……	☐	☐
PACEMAKER……..	☐	☐	PERIPHERAL VASCULAR DISEASE……..	☐	☐

NEUROLOGICAL:	**YES**	**NO**		**YES**	**NO**
HEADACHES/MIGRAINES……	☐	☐	ANXIETY/DEPRESSION……	☐	☐
SEIZURES/CONVULSIONS……..	☐	☐	STROKE/PARALYSIS/WEAKNESS……	☐	☐
ALZHEIMERS/DEMENTIA……	☐	☐	PSYCHIATRIC DISORDER……..	☐	☐
PARKINSONS/TREMORS……	☐	☐	CLAUSTROPHOBIA……..	☐	☐
DIZZINESS/VERTIGO/FAINTING……	☐	☐	CAROTID ARTERY DISEASE……..	☐	☐

GASTROINTESTINAL:	**YES**	**NO**		**YES**	**NO**
ULCER……	☐	☐	LIVER PROBLEMS/CIRRHOSIS……..	☐	☐
HEPATITIS……	☐	☐	BLACK/BLODDY STOOLS……	☐	☐
CIRCLE ONE TYPE: ***A B C***			ACID REFLUX/HEARTBURN/HIATAL HERNIA…….	☐	☐

GENITOURINARY:	**YES**	**NO**		**YES**	**NO**
INCONTINENCE……	☐	☐	KIDNEY PROBLEMS……..	☐	☐
HESITANCY/DEREASE STREAM…….	☐	☐	DIALYSIS……..	☐	☐
			HOW OFTEN:_____		
PAINFUL URINATION……..	☐	☐	PROSTATE PROBLEMS……	☐	☐
			PROSTATE MEDICATION?.....	☐	☐

MUSCULOSKELETAL:	**YES**	**NO**		**YES**	**NO**
ARTHRITIS……..(OSTEO)……..	☐	☐	PAIN/MISALIGNMENT……	☐	☐
RHEUMATOID ARTHRITIS……	☐	☐	CAN YOU LIE FLAT?.....	☐	☐
CHRONIC PAIN……	☐	☐	DECREASED RANGE OF MOTION……..	☐	☐
LUPUS……	☐	☐	HEAD/SPINAL INJURY……	☐	☐

HEMATOLOGIC:	**YES**	**NO**		**YES**	**NO**
SICKLE CELL DISEASE……..	☐	☐	TEMPORAL ARTERY DISEASE……	☐	☐
HISTORY OF BLOOD CLOTS……	☐	☐	ANEMIA……..	☐	☐
EXCESSIVE BLEEDING/BRUISING….	☐	☐	HIV/AIDS……	☐	☐

ANY ADDITIONAL MEDICAL ISSUE :	**YES**	**NO**
PLEASE EXPLAIN:	☐	☐

_____

_____

_____

_____