THE MIDWEST CENTER FOR SIGHT

Medical History Form

Name: ____

Date: ___________________

Past Medical History: (please **circle** all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Bladder Condition
Cancer___________________________
Chemo/Radiation Treatment
COPD
Depression
Diabetes **Type I** **Type II**
GERD
Hearing Loss
Hepatitis
Heart Disease_____________________
High Blood Pressure
Low Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Kidney Disease
Leukemia
Pacemaker
Prostate Condition: **Enlarged - Cancer**
Seizures
Skin: **Basal Cell – Squamous - Melanoma**
Stroke
Valve Replacement
None
Other ____

Past Surgical History: (please **circle** all that apply)

Appendix Removed
Bladder Removed
Mastectomy /Lumpectomy **Right** **Left**
Colectomy
Gallbladder Removed
Heart Surgery____________________
Hysterectomy
Other ______________________________
Joint Replacement: Knee **Right** **Left**
Hip **Right** **Left**
Kidney Surgery___________________
Prostate Surgery
Rotator Cuff: **Right** **Left**
Skin Surgery_____________________
None

Eye History: (please **circle** all that apply)

Allergic conjunctivitis
Blepharitis
Cataract
Corneal dystrophy
Diabetic retinopathy
Dry eyes/Artificial Tears **Yes** **No**
Glaucoma
Macular degeneration
ERM – Epi Retinal Membrane
Narrow angles
Ocular hypertension
Ophthalmic Migraine
Retinal tear
Retinal detachment
Strabismus/Eye Muscle
PVD – Posterior Vitreous Detachment
Vitreous floaters
None
Other ____

Please Turn Page Over

Eye Surgery: (please circle all that apply)

Blepharoplasty
Cataract surgery
Corneal transplant /DSAEK
Eye Muscle Surgery
Glaucoma Surgery_____________
Intravitreal injections
Laser Surgery________________
LASIK /PRK
Other ____

Ptosis repair
Punctal plugs
Retinal Surgery
Tube Shunt
None

Family History: (please circle all that apply) List Family member:

Blindness____________________________
Cancer______________________________
Cataracts____________________________
Diabetes_____________________________
Glaucoma____________________________
Heart disease_________________________
Macular degeneration_________________
Other ____

Migraine_____________________________
Retinal detachment__________________
Strabismus___________________________
Stroke________________________________
None

Medications: (Please **list** all current medications)

Name	Dosage	How Often

None

Allergies: (Please **list** all allergies)

____

____

None

Social History: (Please circle all that apply)

Cigarette/Cigar Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily
- E Cigarettes

Illicit Drug Use:
Drug Use ____________________________
IV Drug Use __________________________

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Activity:
Do you drive during the day? **YES NO**
Do you drive at night? **YES NO**

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