OPHTHALMIC CONSULTANTS OF BOSTON
EXCELLENCE IN EYE CARE

Medical History and Review of Systems

Date of Appointment: _____

Provider: _____

NAME: _____

ADDRESS: _____

_____

TELEPHONE:_____

Medical Doctor (not eye):
_____
Address:

Date of Birth: _____ **Age:** _____

REASON FOR VISIT: _____

MEDICAL HISTORY **PLEASE CHECK "No or "Yes" for each area**

A) How would you rate your health? **Poor** **Fair** **Good** **Excellent**

B) Please indicate if you currently have or had: **Dates/Explain:**

1)	**Fever, chills, night sweats, unexplained fatigue**	☐ No	☐ Yes	_____
2)	**Have you gained or lost more than 10 pounds in the past year?**	☐ No	☐ Yes	_____
3)	**Ear problems: loss of hearing, vertigo**	☐ No	☐ Yes	_____
4)	**Nose problems: smell, sinus disease**	☐ No	☐ Yes	_____
5)	**Throat problems: dry mouth, difficulty swallowing**	☐ No	☐ Yes	_____
6)	**Heart or circulation problems**			
	Heart attack, angina	☐ No	☐ Yes	_____
	Congestive heart failure, shortness of breath	☐ No	☐ Yes	_____
	Irregular or rapid heartbeat	☐ No	☐ Yes	_____
	Cardiac pacemaker or heart valve	☐ No	☐ Yes	_____
	High blood pressure or high cholesterol	☐ No	☐ Yes	_____
7)	**Respiratory problems**			
	Asthma	☐ No	☐ Yes	_____
	Chronic cough, emphysema, bronchitis, sleep apnea	☐ No	☐ Yes	_____
	Tuberculosis, positive skin date ____	☐ No	☐ Yes	_____
8)	**Gastrointestinal problems**			
	Ulcer, diverticulitis, colitis, frequent diarrhea	☐ No	☐ Yes	_____
	Liver disease, hepatitis (type _____)	☐ No	☐ Yes	_____
9)	**Genitourinary**			
	Kidney, bladder, prostate problems stones, infections, frequency, VD	☐ No	☐ Yes	_____
10)	**Muscle or joint problems**			
	Weakness, inflammation, low back pain	☐ No	☐ Yes	_____
	Osteoarthritis, rheumatoid, gout,fatigue arthritis, joint swelling	☐ No	☐ Yes	_____
11)	**Skin, nail or hair problems**			
	Eczema, psoriasis, rosacea, infections	☐ No	☐ Yes	_____
12)	**Nervous system problems**			
	TIA, stroke, seizures, difficulty walking, tremor, Parkinson's disease	☐ No	☐ Yes	_____
	Memory loss, disorientation, hallucinations	☐ No	☐ Yes	_____
	Depression, anxiety, other	☐ No	☐ Yes	_____

13) Endocrine problems

Diabetes: **Date of onset:** _____ **Duration:**_____

Complications: ☐ kidney ☐ neuropathy ☐ vascular ☐ ocular

Treatment: ☐ diet ☐ oral agents ☐ insulin

Thyroid Disease ☐ underactive ☐ over active treatment_____

☐**Adrenal** ☐ **Pituitary** (*hair loss, unusual hand/foot growth, abnormal menstrual cycle, heat/cold intolerance, change in libido)*

14) Blood disorders ☐ easy bruising ☐ anemia ☐ clot in legs ☐ recurrent infections ☐ swollen glands

15) Transfusions of blood or plasma:_____

16) AIDS or HIV positive (date of test):_____

17) Cancer or tumor: Type, location, date, treatment:_____

18) If applicable, are you pregnant? ☐No ☐Yes Expected Date of Delivery_____

19) Other medical problems:

_____

ALLERGIES: Medications, foods, chemicals, environment. (Please describe reaction and when it occurred.)

_____

_____

PHARMACY: _____

MEDICATIONS: (give name, dosage, frequency)

Eye Medications:_____

_____

Prescription Medications:_____

_____

Non-Prescription Medications:_____

_____

When did you last take aspirin in any form?_____

SURGERY: Have you had any previous **eye surgery, laser eye surgery** or **eye injury**? ☐ No ☐ Yes

If yes, please give name(s) of operation(s) or injuries and date(s):_____

_____

What non-ocular operations or hospitalizations have you had? Please give type(s) and date(s): _____

_____

_____

Date of last **general** anesthesia: _____ Any anesthesia complications? ☐ No ☐ Yes

If yes, describe: _____

DESCRIBE THE EYE PROBLEM(S) YOU ARE HAVING TODAY:_____

_____

_____

_____

SOCIAL HISTORY:

1. Do you smoke? ☐ Yes ☐ No Former smoker? ☐ Yes ☐ No If yes, how many cigarettes per day? _____
Chewing Tobacco? ☐ Yes ☐ No E-cigarettes? ☐ Yes ☐ No Quit date? _____

2. Do you drink alcohol? ☐ Yes ☐ No If yes, drinks per day? _____ Drinks per week: _____

3. Gender: Male ☐ Female ☐

4. Race: ☐ Caucasian ☐ African American ☐ Asian Other _____ ☐ Refused

5. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

6. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

7. Work Status: _____ Current Occupation: _____

8. Any known toxic exposures? ☐ Yes ☐ No

9. Living arrangements: ☐ Home ☐ Apartment ☐ Nursing home ☐ Other: _____

10. Education Level: ☐ Grade School ☐ High School ☐ College ☐ Post-Graduate Degree ☐ Other: _____

11. Are there other problems affecting your health (family illness, deaths, stress, etc)? _____

_____

FAMILY HISTORY: Among your **blood relatives**, is there a history or the following: ☐ Unknown ☐ Adopted

1. Glaucoma	☐ No ☐ Yes _____
2. Macular degeneration	☐ No ☐ Yes_____
3. Retinal Detachment	☐ No ☐ Yes _____
4. Diabetes mellitus	☐ No ☐ Yes _____
5. Breast Cancer	☐ No ☐ Yes _____
6. Colon Cancer	☐ No ☐ Yes _____
7. Coronary Artery Disease	☐ No ☐ Yes _____
8. Heart disease	☐ No ☐ Yes _____
9. Osteoporosis	☐ No ☐ Yes _____

Please give the name, address, and telephone of **any other eye Doctors:** _____

_____

_____

Form completed by: ☐ Patient ☐ Family ☐ Staff