AVERY EYE CLINIC

YOUR VISION IS OUR FOCUS

Board-Certified Medical and Surgical Ophthalmologists
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Please Fill Out the Front and Back of this Medical History Form. Chart#:_____

Name:_____ Date:_____

Family Physician:_____ Referral Source: _____

REVIEW OF SYSTEMS:

Are you currently experiencing any of the following symptoms? (Circle all that apply)

Constitutional
Fever
Fatigue
Poor Appetite
Night Sweats
Chills

Eye
Blurry
Foggy
Glare
Blindness
Tunnel Vision

Ear/Nose/Throat
Congestion
Sore Throat
Hearing Trouble
Ear Ringing
Nose Bleed
Hoarseness

Cardiovascular
Chest Pain/Pressure
Racing Heart
Ankle Swelling

Respiratory
Short of Breath
Cough
Wheezing

Gastrointestinal
Indigestion
Nausea/Vomiting
Diarrhea
Constipation
Tarry/Bloody Stool

Genitourinary
Difficult Urination
Frequent Urination
Burning
Pain

Musculoskeletal
Weakness
Aches
Muscle Cramps

Skin/Breast
Hives
Rash
Sores
Lump
Pain

Neurological
Dizziness
Severe Headache
Neck Pain
Back Pain
Numbness

Psychiatric
Confusion
Poor Memory
Depressed
Poor Sleep
Nervous/Tense

Endocrine
Weight Loss
Weight Gain
Poor Energy

Heme/Lymph
Bruising
Nose Bleed
Lymph Nodes

Allergy/Immune
Sinus
Sneezing
Hay Fever
Frequent Infections

Other: _____

PAST MEDICAL HISTORY: Has the patient had any of the following conditions? *(Circle all that apply)*

Cataracts	Ulcer	Heart Disease	Paralysis	Cancer (type):
Glaucoma	Jaundice	Kidney Stone	Drug Addiction	High Blood Pressure
Hay Fever	Gallstone	Bladder Trouble	Prostate Trouble	Tuberculosis
Asthma	Liver Disease	Thyroid Disease	Nerve Disease	Anemia
Diabetes	Hepatitis	Stroke	Muscle Disease	Bleeding Disorder
Pneumonia	Colitis	Infections	Seizure	High Cholesterol

(over)

OTHER EYE OR MEDICAL PROBLEM:

Eye/Medical Issue	Date	Eye/Medical Issue	Date
1.		4.	
2.		5.	
3.		6.	

PREVIOUS SURGERIES:

Surgery	Date	Surgery	Date
1.		4.	
2.		5.	
3.		6.	

FAMILY HISTORY: Do any of the following illnesses run in the patient's family? *(Circle all that apply)*

Diabetes	Glaucoma	Seizures	Heart Disease
Stroke	Macular Disease	Arthritis	Asthma
High Blood Pressure	Cancer	Migraine Headache	Goiter

Other Illness	Relation	Other Illness	Relation
1.		3.	
2.		4.	

CURRENT MEDICATIONS: *(Prescription, over the counter, herbal/dietary supplements, vitamins)*

1.	5.
2.	6.
3.	7.
4.	8.

DRUG ALLERGIES:

1.	3.
2.	4.

SOCIAL HISTORY:

Do you currently use tobacco? **Y / N** Have you used it in the past? **Y /N** Type_____

How much each day?_____ How long? _ Do you use alcohol? **Y/N**

Type:_____ How much? _____

Do you have a history of drug use or addiction? **Y / N** Type:_____

For office use only: ROS and PFSH Updated

Date:	*Initials:*	*Date:*	*Initials:*
Date:	*Initials:*	*Date:*	*Initials:*