OPHTHALMIC
CONSULTANTS OF
BOSTON
EXCELLENCE IN EYE CARE

Medical History and Review of Systems

Date of Appointment: ____________

Provider: ______________________

NAME: ____

ADDRESS: ____

____

TELEPHONE:__________________________

Date of Birth: ___________________ **Age:** __________

REASON FOR VISIT: ____

Medical Doctor (not eye):
____
Address:

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 _____________________________

Do you have a health care proxy? ☐ No ☐ Yes If yes, please bring a copy of your proxy to your appointment.

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

____

____

Form completed by: ☐ Patient ☐ Family ☐ Staff