

Heimer Eye Care Associates, P.C.

PATIENT MEDICAL HISTORY

NAME: _____ D.O.B.: _____ DATE: _____

CURRENT MEDICATIONS - Please list.

MEDICATION	DOSAGE	HOW OFTEN	MEDICATION	DOSAGE	HOW OFTEN

DO YOU TAKE PRESCRIPTION BLOOD THINNERS? Y N (If yes, circle COUMADIN / WARFARIN / PLAVIX)
 DO YOU TAKE ASPIRIN (EXCEDRIN, ANACIN, ETC.)? Y N HOW MUCH?

SURGICAL HISTORY

SURGERY	DATE	SURGEON	SURGERY	DATE	SURGEON

Have you ever had a complication with ANESTHESIA? (IF YES, please explain on back of page)

MEDICAL HISTORY Please circle CURRENT and PAST MEDICAL CONDITIONS

Arthritis Blood Clots Cancer Depression Diabetes Heart Disease Stroke
 High Blood Pressure High Cholesterol Thyroid Disease Other:

REVIEW OF SYSTEMS Please CIRCLE if you have any of the following symptoms AT THIS TIME:

- | | |
|-------------------------|---|
| CONSTITUTIONAL | fever / weight change / fatigue / headaches |
| ENT / MOUTH / DENTAL | earaches / sinus disease / nose bleeds / mouth sores / sore throat |
| CARDIOVASCULAR | heart trouble / chest pain / palpitations / swelling of feet or hands |
| RESPIRATORY | cough / short of breath / wheezing / asthma / spitting up blood |
| GASTROINTESTINAL | change in bowel movements / nausea / vomiting / heart burn |
| GENITOURINARY | frequent urination / painful urination / blood in urine / kidney stones |
| PSYCHIATRIC | memory loss / confusion / depression / anxiety |
| INTEGUMENTARY | skin rashes / skin lesions |
| NEUROLOGICAL | dizziness / seizures / numbness or tingling / stroke / paralysis |
| MUSCULOSKELETAL | joint pain / joint stiffness / muscle weakness / muscle pain or cramps |
| ENDOCRINE | diabetic / thyroid problems |
| HEMATOLOGIC / LYMPATHIC | bleeding or bruising tendencies / anemia . phlebitis / past transfusion |
| IMMUNOLOGIC | immune deficiency |

Family History: Retinal Detachment / Macular Degeneration / Diabetic Retinopathy / Glaucoma / Cataract
 Other _____

Social History: Occupation (if retired, prior to retirement)
 Smoking Yes / No # of years _____ packs per day _____ date quit _____
 Alcohol Yes / No how much _____
 Lives with spouse / alone / assisted living / nursing home / other

DO YOU DRIVE? Yes / No

Please list all ALLERGIES, especially to medications: Or Circle: NONE _____