BayState® Eye Care Group
MEDICAL HISTORY FORM

[ ] Initial Hx

1. Name: _____ Date: _____

[ ] Updated Hx

2. Do you have now, or have you ever had: Date of Onset:

a. Diabetes Mellitus YES ____ NO ____ _____
Treatment: diet control ____ oral agents ____ Insulin ____
Medical Complications: renal ____ neuropathy ____ vascular ____ other ____

b. Heart attack ..... YES ____ NO ____ _____
Angina or chest pain ..... YES ____ NO ____ _____
Heart failure ..... YES ____ NO ____ _____
Irregular or rapid heart beat ..... YES ____ NO ____ _____
A cardiac pacemaker inserted ..... YES ____ NO ____ _____

c. High blood pressure ..... YES ____ NO ____ _____

d. A stroke or "shock" ..... YES ____ NO ____ _____

e. Anemia ..... YES ____ NO ____ _____

f. Asthma ..... YES ____ NO ____ _____
Emphysema and/or bronchitis ..... YES ____ NO ____ _____
Pneumonia ..... YES ____ NO ____ _____
Tuberculosis ..... YES ____ NO ____ _____

g. Liver disease or jaundice ..... YES ____ NO ____ _____

h. Stomach or duodenal ulcer ..... YES ____ NO ____ _____

i. Kidney stones or other kidney disease YES ____ NO ____ _____

j. Arthritis (if yes, type) ..... YES ____ NO ____ _____

k. Cancer or tumor ..... YES ____ NO ____ _____
Type, location and date _____
Treatment given _____

l. Thyroid disease ..... YES ____ NO ____ _____
Underactive _____ Treatment _____
Overactive _____ Treatment _____

m. Seizures or a nervous breakdown ..... YES ____ NO ____ _____

n. Varicose veins or blood clots in legs ..... YES ____ NO ____ _____

o. Bleeding disorders ..... YES ____ NO ____ _____

p. Transfusions of blood or plasma ..... YES ____ NO ____ _____

q. AIDS, ARC, or HIV positive test ..... YES ____ NO ____ _____

r. Are you currently being treated for MRSA? ..... YES ____ NO ____ _____

s. Have you ever been treated for MRSA in the past or are you colonized with MRSA? YES ____ NO ____
If Yes, how were you treated _____

t. Other medical problems ..... YES ____ NO ____ _____

3. Are you **allergic** to any medications or to any foods? YES ____ NO ____
If yes, please describe substance(s), with date and type of reaction:
_____
_____

4. a. What **eye medications** are you using at present? Give name(s) and dosage:
_____
_____
_____

(over, please)

b. What other medications do you take regularly? Please give name(s) and dosage:

_____

_____

_____

_____

When did you last use aspirin, in any form? _____

5. Have you had any previous **eye surgery/laser** or injuries? YES ____ NO ____

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

_____

_____

_____

6. What (if any) other operations have you had? Please give type(s) and date(s):

_____

_____

_____

7. Among your blood relatives, is there a history of any of the following:

a. Glaucoma ..... YES ____ NO ____ _____
b. Cataracts ..... YES ____ NO ____ _____
c. "Lazy eye" or muscle imbalance ..... YES ____ NO ____ _____
d. Retinal disease ..... YES ____ NO ____ _____
e. Macular disease ..... YES ____ NO ____ _____
f. Night blindness ..... YES ____ NO ____ _____
g. Color blindness ..... YES ____ NO ____ _____
h. Unexplained vision loss ..... YES ____ NO ____ _____
i. Diabetes mellitus ..... YES ____ NO ____ _____
j. Tumor or cancer ..... YES ____ NO ____ _____
k. High blood pressure ..... YES ____ NO ____ _____
l. Heart disease ..... YES ____ NO ____ _____
m. Bleeding disorder ..... YES ____ NO ____ _____

8. Please give the name, address and telephone number of your personal **medical** doctor (not your eye doctor):

_____ , M.D.

_____

_____ Telephone ( ) _____

9. Please give the name, address and telephone number of the physician, family member or friend who referred you to our office:

_____

_____

_____ Telephone ( ) _____

_____

(Patient's Signature)