Integrated Vision Associates

Medical History

Your Information

1. What is your name?:_____ Today's date:_____

Medical History

2. Primary care doctor:_____ Tel:_____

3. Do you now, or have you ever had: Diagnosis date:

a. Diabetes . . . . . .Yes □ No □ _____
Treatment: diet control □ oral agents □ insulin □ other □ _____
Medical complication: kidney □ vascular □ eye □ other □
b. Heart attack . . . . . .Yes □ No □ _____
Angina or chest pain . . . . . .Yes □ No □ _____
Heart failure . . . . . .Yes □ No □ _____
Irregular or rapid heartbeat . . . . . .Yes □ No □ _____
Cardiac pacemaker inserted . . . . . Yes □ No □ _____
c. High blood pressure . . . . . Yes □ No □ _____
d. Stroke or TIA . . . . . 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 / other kidney diseases . . . . . .Yes □ No □ _____
j. Arthritis: rheumatoid □ osteo □ . . . . . Yes □ No □ _____
k. Cancer or tumor . . . . . Yes □ No □ _____

Type:_____

Treatment:_____

l. Thyroid disease: underactive □ overactive □. . . . . .Yes □ No □ _____
Treatment:
m. Migraine . . . . . .Yes □ No □ _____
n. Blood clot in legs . . . . . Yes □ No □ _____
o. Bleeding disorders . . . . . Yes □ No □ _____
p. Transfusions of blood or plasma . . . . . Yes □ No □ _____
q. HIV positive, AIDS. . . . . .Yes □ No □ _____
r. Other medical problems . . . . . .Yes □ No □ _____
Please describe:

4. Are you allergic to any medications or foods? . . . . . Yes □ No □ _____
If yes, please describe substance(s), with type of reaction: _____

Medications

5. Please list all medications you are using at present in the spaces provided below:

Eye medication(s)			All other medication(s)		
Name	**Dose**	**Frequency**	**Eye**	**Name**	**Dose** **Frequency**

Eye Care History

6. Eye doctors seen:_____
Have you ever had any eye injuries? . . . . . Yes □ No □
If yes, please describe injuries and dates:_____
7. Have you ever had any previous eye surgery or laser treatment? . . . . . Yes □ No □
If yes, please give name of operations and dates:_____
8. What other operations have you had? Please give types and dates:_____

_____

Systems Review

9. Are you currently having problems with any of the following. Please complete and give details:

a. Unexplained weight gain or loss greater than 10 lbs. . . . . .Yes □ No □ _____
b. Fever, chills, night sweats . . . . . Yes □ No □ _____
c. Decreased vision, eye pain, double vision . . . . . .Yes □ No □ _____
d. Decreased hearing, ringing in ears . . . . . .Yes □ No □ _____
e. Nasal congestion, nose bleeds, sinus congestion . . . . . Yes □ No □ _____
f. Hoarse voice, sore throat . . . . . .Yes □ No □ _____
g. Chest pains or heaviness, shortness of breath, leg pain
when walking, ankle swelling, irregular heartbeat . . . . . Yes □ No □ _____
h. Cough, wheezing, coughing up blood or sputum . . . . . Yes □ No □ _____

i. Heartburn, nausea, stomach pain, diarrhea, constipation . . . . . Yes □ No □ _____
j. Problems with kidneys, urination, bladder . . . . . .Yes □ No □ _____
k. Skin rashes or lesions, breast lumps . . . . . .Yes □ No □ _____
l. Headaches, dizziness, muscle weakness . . . . . .Yes □ No □ _____
m. Joint Pain, stiffness, swelling . . . . . .Yes □ No □ _____
n. Depression, nervousness / anxiety . . . . . .Yes □ No □ _____
o. Lymph node swelling, infections . . . . . .Yes □ No □ _____
p. Itching, sneezing / allergy symptoms . . . . . .Yes □ No □ _____

Social and Family History

10. a. Are you a smoker? Yes □ No □ Cigarettes per day:_____ When did you stop? _____
b. Alcohol use? None □ Social □ 2-3x week □ with dinner □ other □
c. Occupation: _____Live alone: Yes □ No □
d. Exercise? None □ Occasionally □ Weekly □ Daily □
e. Do you drive? . . . . . .Yes □ No □

11. Among your blood relatives, is there any history of any of the following? List: mother, father, sister, brother, etc.

a. Glaucoma . . . . . Yes □ No □ _____
b. Cataracts . . . . . .Yes □ No □ _____
c. "Lazy eye" or muscle imbalance . . . . . Yes □ No □ _____
d. Retinal disease or macular disease . . . . . .Yes □ No □ _____
e. Migraine . . . . . Yes □ No □ _____
f. Night blindness/color blindness . . . . . Yes □ No □ _____
g. Unexplained vision loss . . . . . Yes □ No □ _____
h. Diabetes mellitus . . . . . Yes □ No □ _____
i. Tumor or cancer . . . . . Yes □ No □ _____
j. High blood pressure . . . . . Yes □ No □ _____
k. Heart disease . . . . . Yes □ No □ _____
l. Bleeding disorder . . . . . Yes □ No □ _____

12. If applicable, are you pregnant? . . . . . Yes □ No □ _____
13. Interested in Laser Vision Refractive Surgery (LASIK)? . . . . . Yes □ No □ _____

Patient signature: _____ Doctor signature: _____ Technician signature: _____