# MEDICAL HISTORY

(Please Print)

Patient's Name: _____ Age: _____ Sex: _____

Primary Care Physician (PCP): _____ Were you referred by your PCP? Yes No

**DO YOU GIVE PERMISSION FOR DR. SINGH TO DO A COMPLETE MEDICINE RECONCILLIATION? YES / NO**
**(This is done for your protection in regard to possible drug interaction.)**

1. Are you **currently** experiencing any eye symptoms? (Yes / No) If yes, please circle all that apply:

| | | | |
|---|---|---|---|
| Eye Pain | Blurred Vision | Eyelid Crusting | Flashes of Light |
| Halos | Red Eyes | Light Sensitivity | Double Vision |
| Floaters | Discharge | Eye Pressure | Foreign Body Sensation |

2. Please circle any of the following you would like more information about:

| | | |
|---|---|---|
| Cataract Surgery | Macular Degeneration | Diabetic Eye Disease |
| Glaucoma | Laser Vision Correction | Other: _____ |

3. Please answer the following questions about your medical status and history:
   1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)
      Yes ◇ No ◇ If YES, please explain: _____
   2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment, eye injury)
      Yes ◇ No ◇ If YES, please explain: _____
   3. Have you ever had any eye surgery?
      Yes ◇ No ◇ If YES, please explain: _____
   4. Have you ever been hospitalized?
      Yes ◇ No ◇ If YES, please explain: _____
   5. Do you take medications?
      Yes ◇ No ◇ If YES, please explain: _____
   6. Do you take/use any eye medications:
      Yes ◇ No ◇ If YES, please explain: _____
   7. Do you have any drug or food allergies?
      Yes ◇ No ◇ If YES, please explain: _____

## REVIEW OF SYSTEMS

| Do you **currently** have any of the following problems: | Yes | No | If Yes, please explain |
|---|---|---|---|
| Chronic fever, unexpected weight loss/gain, fatigue | ◇ | ◇ | _____ |
| Ear/nose/throat problems (e.g., hearing loss, sinus problems) | ◇ | ◇ | _____ |
| Heart problems (e.g., chest pain, irregular heart beat) | ◇ | ◇ | _____ |
| Respiratory problems (e.g., shortness of breath, wheezing, coughing) | ◇ | ◇ | _____ |
| Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea) | ◇ | ◇ | _____ |
| Urinary problems (e.g., pain discomfort, blood in urine) | ◇ | ◇ | _____ |
| Skin problems (e.g., rashes, excessive dryness) | ◇ | ◇ | _____ |
| Musculloskeletal problems (e.g., muscle aches, joint pain) | ◇ | ◇ | _____ |
| Neurological problems (e.g., numbness, weakness, headaches) | ◇ | ◇ | _____ |
| Psychiatric problems (e.g., depression, anxiety) | ◇ | ◇ | _____ |

## FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
◇ Yes ◇ No If Yes, please explain _____

Do you smoke? ◇ Yes ◇ No If Yes, how much? _____ Drink alcohol? ◇ Yes ◇ No If Yes, how much? _____

_____