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Lee Eye Surgery Clinic, P.A.

Medical History Form

Patient Name: _____ Date: _____ [] Initial [] Updated

Social Security #: _____ Date of Birth: _____ Medical Record #: _____

What specific visual difficulties are you experiencing now? _____

Do you have now or have you ever had:

If YES, please explain

- A. Diabetes, mellitus [] No [] Yes _____
If yes, duration and treatment _____
- B. Heart Attack [] No [] Yes _____
Angina or Chest Pain [] No [] Yes _____
Heart Failure [] No [] Yes _____
Irregular or Rapid Heart Beat [] No [] Yes _____
A Cardiac Pacemaker Inserted [] No [] Yes _____
- C. High Blood Pressure [] No [] Yes _____
- D. A Stroke or "Shock" [] No [] Yes _____
- E. Anemia [] No [] Yes _____
- F. Asthma [] No [] Yes _____
- G. Stomach or Duodenal Ulcer [] No [] Yes _____
- H. Kidney Stones or Other Kidney Disease [] No [] Yes _____
- I. Arthritis (if Yes, Type) [] No [] Yes _____
- J. Cancer or Tumor [] No [] Yes _____
Type, Location and Date [] No [] Yes _____
Treatment Given [] No [] Yes _____
- K. Thyroid Disease [] No [] Yes _____
- L. Seizures or a Nervous Breakdown [] No [] Yes _____
- M. Varicose Veins or Blood Clots in Legs [] No [] Yes _____
- N. Other Medical Problems [] No [] Yes _____
- O. Weight gain or loss more than 10 lbs in the past year? [] No [] Yes _____

Are you **ALLERGIC** to any medications or to any foods? [] No [] Yes _____

Eye Medications: _____ **Other Medications:** _____

Eye Surgery or Injury? [] No [] Yes If Yes, please give name(s) of operation(s) or injuries and date(s) and indicate which eye(s): _____

What operations other than eye surgery have you had? Please give type(s) and date(s): _____

Do you wear glasses? No Yes Do you wear contacts? No Yes If Yes, type of contacts _____, how long? _____

Do you smoke? No Yes If Yes, how many per day for how many years? _____

If No, and you smoked in the past, how many did you smoke for how long and when did you quit? _____

Do you consume alcohol? No Yes If Yes, how many drinks per week for how many years? _____

Occupation: _____ if retired, what was your occupation: _____

Hobbies: _____

Among your blood relatives, is there a history of any of the following? If Yes, who has it?

- | | | |
|--------------------------------|--|-------|
| Glaucoma | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Cataract | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| “Lazy Eye” or muscle imbalance | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Retinal Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Macular Disease | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Night Blindness | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Color Blindness | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Unexplained Visual Loss | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Diabetes Mellitus | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Tumor or Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| High Blood Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Bleeding Disorder | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Blindness from Any Cause | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |

If applicable, are you pregnant No Yes _____

Who is your Primary Medical Doctor: _____

Address: _____ Phone: _____

Patient Signature: _____