

Groat Eyecare Associates, P.A.
MEDICAL HISTORY (ROS, PH, SH, FH)

Name _____ Date _____

Eye Symptoms, past or present. Please circle YES or NO

Blurry vision	YES	NO	Loss of side vision	YES	NO
Burning	YES	NO	Loss of vision	YES	NO
Infection	YES	NO	Mucous discharge	YES	NO
Double vision	YES	NO	Pain or soreness	YES	NO
Dry eyes	YES	NO	Redness	YES	NO
Tearing	YES	NO	Stye	YES	NO
Fluctuating vision	YES	NO	Trouble reading	YES	NO
Foreign body sensation	YES	NO	Blurry distance vision	YES	NO
Light sensitivity	YES	NO	Night vision problems	YES	NO
Itching	YES	NO	Other eye symptoms	YES	NO

If you answered YES to any of the above questions, please explain here:

Eye Diseases

Cataracts	YES	NO
Glaucoma	YES	NO
Crossed eyes	YES	NO
Retinal detachment	YES	NO
Macular degeneration	YES	NO
Eyelid problems	YES	NO
Eye injuries	YES	NO
Other	YES	NO

If you answered YES to any of the above questions, please explain here:

Please List Previous Eye Surgery

Please List Eye Medications

General Review of Symptoms – (Circle Y for YES and N for NO)

Constitutional

Fever Y N
 Weight loss Y N
 Cancer Y N

Gastrointestinal

Hepatitis Y N
 Ulcers Y N
 Bleeding Y N
 Other Y N

Musculoskeletal

Arthritis Y N
 Broken bones Y N

Ear, Nose, Throat

Hearing problems Y N
 Sinus disease Y N
 Cough Y N
 Other Y N

Genitourinary

Kidney disease Y N
 Prostate disease Y N
 Prostate disease Y N
 Pregnancy Y N

Psychiatric

Depression Y N
 Alzheimer's Y N
 Dementia Y N
 Other Y N

Cardiovascular

Heart Attack Y N
 High blood pressure Y N
 Chest pain (angina) Y N
 Pacemaker Y N
 Bypass Surgery Y N
 Other Y N

Skin

Skin disease Y N
 Rash Y N

Hematologic

Anemia Y N
 Bleeding Y N
 Lymph nodes Y N
 Other Y N

Respiratory

Asthma Y N
 Emphysema Y N
 Breathing problems Y N
 Other Y N

Neurological

Migraine Y N
 Headaches Y N
 Stroke Y N
 Dizziness Y N
 Other Y N

Allergic/Immunologic

Allergy symptoms Y N
 Immune problems Y N
 AIDS (HIV) Y N

Endocrine

Diabetes Y N
 Thyroid disease Y N
 Other Y N

If you answered YES to any of the above questions, please explain here:

Name _____ Date _____

Past History

Please list current medications:

List any past surgery:

Are you allergic to any medications? Yes No If so, please list medication and describe your reaction:

Please list here any other problems or symptoms not mentioned above that may relate to your health or your eyes:

Family History – (parent, grandparent, sibling, child – if YES, tell who has the history)

Diabetes	Y	N	Crossed Eyes	Y	N
Heart disease	Y	N	Blindness	Y	N
Glaucoma	Y	N	Other	Y	N
Cataracts	Y	N			

Social History - (circle Y for YES and N for NO)

Drug problem	Y	N
Alcohol use	Y	N
Smoking	Y	N
Occupational exposure	Y	N

Patient (or representative) Signature _____

Physician Signature _____

PH, RH, SH, ROS Update Information

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Date:
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