Greenberg Laser Eye Center
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MEDICAL HISTORY

Name: _____ Date of Birth:_____ Today's Date: _____

Allergies: Reaction Severity

□ Sulfa mild/moderate/severe
□ Penicillin mild/moderate/severe
□ Aspirin mild/moderate/severe
□ Codeine mild/moderate/severe
□ Cipro mild/moderate/severe
_____ mild/moderate/severe
_____ mild / moderate / severe
_____ mild / moderate / severe

Current Eye Medications: (Please list)

_____ _____ _____ _____
_____ _____ _____ _____

All Medications (other than eye): (Please list)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Have you been on a medication for a prostate condition? Yes No

Systemic Illnesses / Infections:

□ No history of illnesses
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Chicken Pox
□ Congestive Heart Failure
□ COPD
□ Diabetes
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Hepatitis A / B / C
□ Herpes (including cold sores)
□ High Blood Pressure
□ High Cholesterol
□ Histoplasmosis
□ Herpes Zoster (shingles)
□ HIV / AIDS
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lupus
□ Meningitis
□ Migraine
□ MRSA
□ Multiple Sclerosis
□ Polymyalgia
□ Psychiatric Disorders
□ Rheumatoid Arthritis
□ Sjogren's
□ Skin Cancer
□ Stroke
□ Syphillis
□ Thyroid Disease (Hypo/Hyper)
□ Toxoplasmosis
□ Wound Infection

Other_____

Past Eye History: (Please mark all that apply)

□ Overall Healthy
□ Aphakia
□ Cataracts
□ Cataract Surgery
□ Contact Lens Intolerence
□ Corneal Infection
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Lazy eye – patched / surgery
□ Macular Degeneration
□ Myopia (Nearsighted)
□ Optic Neuritis
□ Retinal Detachment
□ Trauma

Other_____

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General Surgeries / Operations: (Please list)

_____

_____

Eye and Eyelid Surgeries (including cosmetic procedures):

□ No prior eye surgery

Please list all eye surgeries including cosmetic procedures with dates_____

_____

Family History:

□ Arthritis □ Cancer □ Glaucoma □ Macular Degeneration
□ Blindness □ Cataracts □ Lazy Eye □ Retinal Detachment

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Drug Use: □ Yes □ No If yes what and how often?_____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney **Stones**
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure