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) + directions/dosage (mg)

_____ _____ _____ _____

_____ _____ _____ _____

Vaccines last 12 months: Flu? ☐ Yes ☐ No Pneumonia? ☐ Yes ☐ No

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

Systemic Illnesses / Infections/ Medical Diagnoses:

- ☐ No history of illnesses
- ☐ Anemia
- ☐ Arthritis
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer_____
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Diabetes
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ Headache
- ☐ 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
- ☐ Stroke
- ☐ Syphillis
- ☐ Thyroid Disease circle: Hypo / Hyper
- ☐ Toxoplasmosis
- ☐ Wound Infection

Other_____

Past Eye History: (Please mark all that apply)

- ☐ Overall Healthy
- ☐ Aphakia
- ☐ Cataracts
- ☐ Cataract Surgery
- ☐ Contact Lens Intolerance
- ☐ 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:

☐Blindness ☐Glaucoma relation?_____living or deceased ☐Macular Degeneration
☐Cataracts under 50 years old ☐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 / Hepatitis

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