

The Eye Center of Southern Indiana
Medical History / Interval History

Thank you for choosing us for your vision care. Current medical information is essential for quality eye care.

Patient Name: _____ Sex: ___ Male ___ Female Birth date: ___ / ___ / ___

Primary Care Physician: _____ Specialty Physicians: _____

Do you take any medications? Please list them.

Name / # mg / times per day	Name / # mg / times per day	Name / # mg / times per day

Are you allergic to any medications? Please list them.

Do you have any of the following medical problems? Put a “+” sign if so.

<input type="checkbox"/> diabetes	<input type="checkbox"/> kidney disease	<input type="checkbox"/> stroke	<input type="checkbox"/> eczema
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> cancer	<input type="checkbox"/> Alzheimer’s / dementia	<input type="checkbox"/> high cholesterol
<input type="checkbox"/> heart disease	<input type="checkbox"/> arthritis	<input type="checkbox"/> TB	<input type="checkbox"/> overactive thyroid
<input type="checkbox"/> COPD / lung disease	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> HIV / AIDs	

Have you had any of the following surgeries? Put a “+” sign if so.

<input type="checkbox"/> heart bypass	<input type="checkbox"/> heart “balloon”	<input type="checkbox"/> knee replacement	<input type="checkbox"/> tonsils	<input type="checkbox"/> other(s):
<input type="checkbox"/> heart valve	<input type="checkbox"/> hip replacement	<input type="checkbox"/> knee repair	<input type="checkbox"/> appendix	
<input type="checkbox"/> heart stent	<input type="checkbox"/> hysterectomy	<input type="checkbox"/> carpal tunnel	<input type="checkbox"/> gall bladder	
<input type="checkbox"/> heart pacemaker	<input type="checkbox"/> mastectomy	<input type="checkbox"/> hemorrhoid	<input type="checkbox"/> prostate	

Do any of the following apply to you? Put a “+” sign if so.

<input type="checkbox"/> cigarette smoker	<input type="checkbox"/> reside in nursing home	<input type="checkbox"/> currently employed	<input type="checkbox"/> on disability
<input type="checkbox"/> drug dependency	<input type="checkbox"/> drives automobile	<input type="checkbox"/> currently retired	<input type="checkbox"/> need wheelchair

Does your family have a history of any of the following problems? Put a “+” sign if so.

<input type="checkbox"/> TB	<input type="checkbox"/> cancer	<input type="checkbox"/> glaucoma	<input type="checkbox"/> retinal detachment
<input type="checkbox"/> diabetes	<input type="checkbox"/> macular degeneration	<input type="checkbox"/> cataract	<input type="checkbox"/> corneal transplant

Have you experienced any of the following symptoms in the past month? Put a “+” sign if so.

<u>General</u>	<u>Ears, nose & throat</u>	<u>Heart & circulation</u>	<u>Breathing</u>	<u>Stomach & intestines</u>
<input type="checkbox"/> fever	<input type="checkbox"/> sinus pain	<input type="checkbox"/> angina	<input type="checkbox"/> wheezing	<input type="checkbox"/> vomiting
<input type="checkbox"/> weakness	<input type="checkbox"/> chronic cough	<input type="checkbox"/> fainting spells	<input type="checkbox"/> short of breath	<input type="checkbox"/> chronic diarrhea
<u>Hormones</u>	<u>Muscles & bones</u>	<u>Nerves</u>	<u>Allergies</u>	<u>Mood</u>
<input type="checkbox"/> heat intolerance	<input type="checkbox"/> joint pain	<input type="checkbox"/> severe head ache	<input type="checkbox"/> seasonal allergies	<input type="checkbox"/> depression
<input type="checkbox"/> gynecologic	<input type="checkbox"/> back stiffness	<input type="checkbox"/> disoriented	<input type="checkbox"/> red, irritated skin	<input type="checkbox"/> severe anxiety

The following section is to be filled out by The Eye Center staff.

Date reviewed: _____

Signed: _____

Date reviewed: _____

Signed: _____

This side is for staff use only.

**The Eye Center of Southern Indiana
Ocular History & Problem List**

Patient Name: _____

Primary Care Optometrist: _____

Ocular Surgery List

Procedure	Mo / Yr	Surgeon	Procedure	Mo / Yr	Surgeon

Ocular Problem List

Diagnosis	Mo / Yr	Diagnosis	Mo / Yr	Diagnosis	Mo / Yr

Family Ocular History

Diagnosis	
Relation	

Ancillary Clinical Procedures List

Fluorescein Angiography	
Fundus Photography	
External / slit lamp photo	
Visual Fields	
Orbscan	
OCT	
Pachymetry	

Glasses

Mo / Yr / Dr.	OD	Mo / Yr / Dr.	OD
	OS		OS
Mo / Yr / Dr.	OD	Mo / Yr / Dr.	OD
	OS		OS
Mo / Yr / Dr.	OD	Mo / Yr / Dr.	OD
	OS		OS
Mo / Yr / Dr.	OD	Mo / Yr / Dr.	OD
	OS		OS
Mo / Yr / Dr.	OD	Mo / Yr / Dr.	OD
	OS		OS

