The Eye Center of Southern Indiana

Medical History / Interval History

Patient Name:____ Sex:___Male ___Female Birth date:____/____/____

Primary Care Physician:______________________________ Specialty Physicians:_________________________

Pharmacy:____ Today's date:___________________________

Do you have any of the following eye problems? Put a "+" sign if so.

__macular degeneration	__diabetic eye disease	__ floaters	__ glaucoma borderline	__ retinal tearing
__cataracts	__ eye trauma	__ glaucoma	__ retinal detachment	__ other (specify)

Have you had any of the following eye surgeries? Put a "+" sign if so. Please include month & year of surgery.

___ retinal laser	___ after cataract laser	___injections to the eye (left / right)
___ diabetic laser	___ glaucoma laser	___LASIK
___ cataract	___ eyelid repair (left / right)	___other (specify)

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

___ AIDS / HIV	___ COPD / lung disease	___ high blood pressure	___ stroke
___ Alzheimer's / dementia	___ diabetes	___ high cholesterol	___ TB
___ arthritis	___ eczema	___ kidney disease	___ thyroid
___ cancer	___ heart disease	___ osteoporosis	___ other (specify)

Have you had any of the following surgeries? Put a "+" sign if so. Please include month & year of surgery.

___ appendix	___ heart "balloon"	___ heart valve	___ hysterectomy	___ other (specify)
___ breast	___ heart bypass	___ hemorrhoid	___ knee repair	_____________
___ carpal tunnel	___ heart pacemaker	___ hernia repair	___ knee replacement	_____________
___ gall bladder	___ heart stent	___ hip replacement	___ prostate	

Does your family have a history of any of the following problems?
Put a (M) mother, (F) father, (S) sibling, (G) grandparent, (R) family

___ blindness	___ corneal transplant	___ macular degeneration	___ TB
___ cancer	___ diabetes	___ retinal detachment	___ other
___ cataract	___ glaucoma	___ retinal disease	

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

___ alcohol use	___ married	___divorced	___ active in sports	___ retired
___ cigarette smoker	___ single	___ other	___ drive automobile	___ need wheelchair
___ drug dependency	___widowed	___ on disability	___ employed	___ reside in nursing home

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

General	*Ears, nose & throat*	*Breathing*	*Heart & circulation*	*Stomach & intestines*
__fever	__hearing loss	__wheezing	__angina	__vomiting
__insomnia	__dizziness	__breathing heavy	__palpitations	__heartburn
__weakness	__ringing	__short of breath	__chest pain	__nausea

__skin lesions	__chronic cough		__fainting spells	__chronic diarrhea
Muscle & bones	*Nerves*	*Hormones*	*Mood*	*Allergies*
__joint pain/stiffness	__severe headache	__heat intolerance	__depression	__seasonal allergies
__back pain	__ memory deficit	__gynecologic	__severe anxiety	__red, irritated skin
	__seizure disorder	__excessive thirst		

Are you allergic to any medications? Please list medication and allergic reaction.

Please list all of the medicines, vitamins, and supplements you take

Drug name	mg/dose	Times per day	Purpose

(including all inhalers, injections, and/or eye drops)