Michigan Oculofacial Specialists

PATIENT MEDICAL, SOCIAL & FAMILY HISTORY

NAME: ______________________________ **DATE:** ______________________________

Review of Systems Please check the box beside any problem you currently have or have ever had, in the following areas:

Allergic / Immunologic
- Allergy/Hayfever

Cardiovascular / Cardiac
- Arteriosclerosis
- Heart Disease
- High Blood Pressure
- High Cholesterol

Ears, Nose, Mouth, Throat
- Sinus Congestion
- Dry Throat/Mouth

Endocrine
- Diabetes
- Thyroid Disease

Hematologic / Lymphatic
- Anemia
- Bleeding Problems
- Breast Cancer

- Anxiety
- Depression

Integumentary (skin)
- Cancer (skin)
- Rashes
- Easy Bruising

Musculoskeletal
- Rheumatoid Arthritis
- Muscle or Joint Pain

Neurological
- Headaches
- Seizures

Respiratory
- Asthma
- Bronchitis
- Emphysema

G.I.
- ☐ Reflux ☐ Ulcer
- ☐ Other ______________________

THIS SECTION MUST BE COMPLETED: Have you had exposure to HIV or Hepatitis ☐ yes ☐ no

Currently Pregnant (female only) ☐ yes ☐ no Visual Difficulty when driving ☐ yes ☐ no

EYE HISTORY

Are you currently experiencing any of the following problems with your eye? **Check the box if "Yes."**

- Blurred Vision
- Loss of Vision
- Loss of Side Vision
- Double Vision
- Tired eyes
- Flashes / Floaters in Vision
- Itching
- Halos
- Glare/Light Sensitivity
- Dryness
- Sandy or Gritty Feeling
- Foreign Body Sensation
- Burning
- Styes or Chalazion
- Redness
- Excess Tearing / Watering
- Eye pain or Soreness
- Mucous Discharge
- Chronic Infection of the Eye or Eyelid

Have you been diagnosed with any of the following eye problems? **Check the box if "Yes."**

- Cataracts
- Glaucoma
- Retinal Detachment
- Macular Degeneration
- Lazy Eye
- Drooping Eyelid

☐ Other Eye History/Injuries ______________________________

Past Surgical & Medical Conditions - List date, type, and/or complications

Surgical Procedures or Medical Conditions	Date or Year

Please turn this form over and complete side two ➔➔➔➔➔➔

Are you Allergic to Any Medications: ___ NO ___ Yes If Yes, List Below, include any Reaction:

PLEASE LIST BELOW ALL ALLERGIES TO MEDICATIONS AND ANY REACTIONS:

MEDICATION	REACTION	MEDICATION	REACTION

LATEX ALLERGY ☐ NO ☐ YES Reaction______________TAPE ALLERGY ☐ NO ☐ YES Reaction ____________

***** Please list all your prescription medications and complete each column ***It is very important to indicate the reason for taking the medications*****

PRESCRIPTION MEDICATIONS	DOSAGE	HOW OFTEN	REASON FOR USING

******PLEASE LIST ALL (NON-PRESCRIPTIONS MEDICATIONS) VITAMINS, MINERALS, HERBS, ASPIRIN, MOTRIN ALEVE, ADVIL, ETC. It is important to indicate the reason for taking the medications*****

DRUG NAME	DOSAGE	HOW OFTEN	REASON FOR USING

PLEASE LIST ALL PRESCRIPTION AND NON PRESCRIPTION EYE DROPS OR OINTMENTS YOU ARE CURRENTLY USING

Print Name:____

SIGNATURE: ____ **DATE:** ___________________________________