BUENA VISTA OPTOMETRY

MEDICAL HISTORY / REVIEW OF SYSTEMS

Name: _____ Allergies to Meds: _____

Date of Birth: _____ Sex: M / F Height: _____ Weight: _____

Primary MD: _____

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING: (CIRCLE any that apply or "none")

Cardiovascular: None / Heart Disease / High Blood Pressure / High Cholesterol
Respiratory: None / Asthma / COPD
Gastrointestinal: None / Hepatitis
Genitourinary: None / Flomax use
Skin / Musculoskeletal: None / Arthritis
Neurologic: None / Previous Stroke
Psychiatric: None / Depression

Endocrine: None / Diabetes, Year Diagnosed: _____
Hematologic: None / Easy Bleeding
Rheumatologic: None / Lupus, RA, Fibromyalgia, Sjögrens
Immunologic: None / HIV-AIDS
Ear / Nose / Throat: None / Allergies
Cancer:
General Health / Other:

FAMILY MEMBER WITH THE FOLLOWING:

Y N GLAUCOMA, Relationship:
Y N MACULAR DEGENERATION, Relationship:
Y N DIABETES, Relationship:

DO YOU DO THE FOLLOWING:

Y N DRINK: How much _____
Y N SMOKE: How much _____

MEDICATIONS (List All): ❑ None

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

NON-OCULAR SURGERIES: ❑ None

_____
_____
_____
_____
_____
_____
_____

FOR OFFICE USE ONLY

OCULAR SURGERIES: ❑ None

Date	Procedure	Eye(s)	Surgeon	Initials/Date

OCULAR DIAGNOSES: ❑ None

_____
_____
_____
_____
_____
_____
_____

HAVE YOU EVER HAD A PROBLEM WITH OUTPATIENT SURGERY OR ANESTHESIA? (Please explain)

❑ No / ❑ Yes: _____