Cumberland Eye Care- Confidential Medical History

Patient Name:_____

EYE HEALTH:

Have you ever had problems in these areas?

Cataracts	Yes	No
Diabetic Retinopathy	Yes	No
Eye Injury	Yes	No
Glaucoma	Yes	No
Lazy Eye/Turning Eye	Yes	No
Macular Disease	Yes	No
Retinal Detachment	Yes	No
Wearing Contact Lenses	Yes	No

Other_____

PAST MEDICAL HISTORY

Have you ever had any problems in the following areas? If so, list diagnosis year.

AIDS/HIV	Yes	No
Arthritis	Yes	No
Asthma/Bronchitis	Yes	No
Cancer	Yes	No
COPD	Yes	No
Defibrillator	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Fainting Spells	Yes	No
Hay Fever / Seasonal	Yes	No
Headaches	Yes	No
Heart Problems	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Kidney Stones	Yes	No
Low Blood Pressure	Yes	No
Lupus	Yes	No
Migraines	Yes	No
MRSA / Staph Infection	Yes	No
Pacemaker	Yes	No
Rosacea	Yes	No
Seizures	Yes	No
Shingles	Yes	No
Slow Heart Rate	Yes	No
Stroke	Yes	No

FAMILY HISTORY:

Have any blood relatives had problems in any of the in any of the following areas?

Blindness	Yes	No
Diabetes	Yes	No
Glaucoma	Yes	No
Macular Disease	Yes	No
Migraine	Yes	No

SOCIAL HISTORY:

Do you drink alcohol?	Yes	No
Do you currently smoke?	Yes	No
Are you pregnant?	Yes	No

REVIEW OF BODY SYSTEMS:

Do you currently have problems with any of the following areas?

Bones, Muscles, Joints	Yes	No
Digestion or Stomach	Yes	No
Ears, Nose, Throat	Yes	No
Heart / Blood	Yes	No
Kidney / Bladder	Yes	No
Lungs	Yes	No
Neck	Yes	No
Nerves	Yes	No
Skin	Yes	No

PLEASE LIST ALL PREVIOUS SURGERIES INCLUDING EYES:

_____
_____
_____
_____

PLEASE LIST ALL MEDICATION *ALLERGIES* AND *REACTIONS*:

_____
_____
_____
_____

PLEASE LIST ALL CURRENT *MEDICATIONS* WITH *DOSAGES* AND REASON FOR TAKING INCLUDING EYE DROPS:

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