MARIETTA EYE CLINIC

Patient MRN#_____

Marietta Eye Clinic Medical History

Date:_____
DOB:_____

Patient Name:_____ Patient Phone#:_____
PCP (Primary Care Physician):_____ Phone #_____
Pharmacy Name & Location_____Phone #_____

MEDICAL HISTORY (Circle any that apply)
Diabetes
High blood pressure
Low blood pressure
Congestive heart failure
Stroke (CVA)
Rheumatoid arthritis
Sjogren's syndrome
Cancer
HIV/AIDS
Hepatitis
Breathing disorder/Lung disease
Kidney disease or disorder
Thyroid disease or disorder
Heart disease or disorder
Migraines
Bleeding disorders
Raynaud's disease
History of steroid use
Other_____

OCULAR HISTORY (Circle any that apply)
Cataracts
Glaucoma
Retinal detachment
Trauma
Muscle disorder (Strabismus)
Lazy eye (Ambylopia)
Ocular migraines
Uveitis
Droopy eyelids
Cornea disorder
Dry eyes

VISION CORRECTION (circle)
Glasses Contact lenses

PEDIATRIC	Yes	No
Born full term		
Reaching developmental milestones		

SURGICAL HISTORY (including eyes)
_____
_____
_____
_____
_____
_____

FAMILY HISTORY	Yes	No	Relation
Glaucoma			
Cancer			
Blindness			
Macular degeneration			
Diabetes			
Retinal detachment			
High blood pressure			
Stroke			
Heart problems			

ALLERGIES
_____
_____
_____
_____
_____

MEDICATION (including dosages, frequency)
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

If you need additional space, continue on the back of paper.

Have you experienced any of the following changes in the last 2 weeks?	Yes	No	Further information:
Chronic fever, unexpected weight loss or gain, fatigue			
Ear, nose, or throat (hearing loss, running nose)			
Cardiovascular (chest pain, irregular heart beat)			
Respiratory (shortness of breath, wheezing)			
Gastrointestinal (heartburn, abdominal pain, diarrhea, constipation)			
Urinary (painful urination, blood in urine, kidney stones)			
Skin (rashes, dryness, nail changes)			
Musculoskeletal (joint pain, aches)			
Neurological (numbness, headaches, stroke)			
Bleeding or clotting			
Psychiatric (anxiety, depression)			
Are you a smoker?			Quit when_____

_____ _____
Patient's signature/representative Date