Central Maine Eye Care, P.A.

Medical History

Name: _____ D.O.B. _____Date: _____

Primary Care Physician: _____ City/State: _____

Do you have any allergies to medications? □ no □ yes If yes, please list:_____

_____

Do you have any environmental allergies? □ no □ yes If yes, please list:_____

_____

List of Medications: (please include oral contraceptives, aspirin, eye drops, and nutritional supplements)

_____

_____

_____

_____

_____

_____

List any major injuries, surgeries, and/or hospitalizations you have had:

_____

_____

_____

Family History

Please note any family history (parents, grandparents, siblings, or children) for the following conditions:

Disease/Condition	No	Yes	?	Relationship to You
Blindness	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Thyroid Disease	□	□	□	_____
Other	□	□	□	_____

Please turn this form over and complete side two

Social History: *This information is strictly confidential. If you would prefer to discuss this directly with your doctor, please check the box below.*

□ I would prefer to discuss my Social History directly with my doctor

Do you use tobacco products? □ No □ Yes If yes, type/amount/how long: _____

Do you drink alcohol? □ No □ Yes If yes, type/amount/how long: _____

Do you use illegal drugs? □ No □ Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ Genital Herpes

Review of Systems:

Do you currently, or have you ever had any problems in the following areas:

System	No	Yes	?
Constitutional			
Significant Weight Gain/Loss	□	□	□
Integumentary (Skin)			
Eczema	□	□	□
Psoriasis	□	□	□
Dermatitis	□	□	□
Herpes Labialis (cold sores)	□	□	□
Ear, Nose, Mouth, Throat			
Sinusitis	□	□	□
Dry Mouth	□	□	□
Chronic Ear Infections	□	□	□
Seasonal Allergies	□	□	□
Dizziness/Vertigo	□	□	□
Respiratory			
Asthma	□	□	□
Chronic Bronchitis	□	□	□
Emphysema/COPD	□	□	□
Shortness of Breath	□	□	□
Tuberculosis	□	□	□
Endocrine			
Thyroid Disease	□	□	□
Hypoglycemia	□	□	□
Prediabetes	□	□	□
Diabetes	□	□	□

System	No	Yes	?
Bones/Joints/Muscles			
Arthritis (Osteoarthritis)	□	□	□
Rheumatoid Arthritis	□	□	□
Psoriatic Arthritis	□	□	□
Lymphatic/Hematologic			
Anemia	□	□	□
Blood Cell Disorder	□	□	□
Bleeding Disorder	□	□	□
Genitourinary			
Kidney Disease	□	□	□
Urinary Tract Disorder	□	□	□
Vascular/Cardiovascular			
High Blood Pressure	□	□	□
High Cholesterol	□	□	□
Heart Disease	□	□	□
CVA (Stroke)	□	□	□
Eyes/Vision			
Dry Eye	□	□	□
Excess Tearing/Watering	□	□	□
Double Vision	□	□	□
Loss of Vision	□	□	□
Flashes/Floaters in Vision	□	□	□
Chronic Eye Infections	□	□	□
Glare/Light Sensitivity	□	□	□

If you have a condition not listed above or would like to provide additional information regarding a particular condition, please comment: _____

_____

_____

Doctor's Signature:_____ Date: _____