EYE CENTER OF CENTRAL GEORGIA
MEDICAL HISTORY SHEET - ADULT

EYE HISTORY:

Please mark any conditions which you have or have ever had:

☐ Glaucoma ☐ Cataracts ☐ Strabismus (Crossed eye)
☐ Retinal disease ☐ Wear glasses/contacts ☐ Amblyopia (Lazy eye)
☐ Headaches ☐ Double vision ☐ Tearing/mattering
☐ Other (please describe): _____

Do any of these conditions run in your family? Explain. _____

Please describe any eye surgeries: _____

If available, please bring records from any eye surgeries.

Please describe any eye injuries: _____

MEDICAL HISTORY:

Have you ever had any problems with the following body systems? **If yes, explain.**

YES◯ NO◯ Unexplained weight loss, chronic fatigue? _____
YES◯ NO◯ High blood pressure or heart problems? _____
YES◯ NO◯ Breathing problems or chronic cough? _____
YES◯ NO◯ Stomach or digestion problems? _____
YES◯ NO◯ Kidney or urinary problems? _____
YES◯ NO◯ Muscle or joint problems? _____
YES◯ NO◯ Skin problems? _____
YES◯ NO◯ Headaches, seizures or nerve problems? _____
YES◯ NO◯ Hormone problems like diabetes or thyroid? _____
YES◯ NO◯ Blood problems like anemia or freebleeding? _____
YES◯ NO◯ Problems with your ears, nose or throat? _____
YES◯ NO◯ Problems with allergies or connective tissue diseases? _____
YES◯ NO◯ Depression or other psychiatric problems? _____

Any other medical problems? (Explain below.)

_____

Do any of the conditions listed above run in your family? Explain.

_____

Please list all the medications which you take.

_____

_____

_____

_____

_____

Please list any drug allergies you have.

_____

Are you allergic to latex? YES◯ NO◯
Do you ever use tobacco products? YES◯ NO◯ If yes, how much? _____
Do you ever drink alcoholic beverages? YES◯ NO◯ If yes, how much? _____
What is your current occupation? _____
Do you have an advance directive? YES◯ NO◯

NAME: _____ **REFERRING DOCTOR:** _____
DATE: _____ **PRIMARY CARE DOCTOR:** _____