Medical History Record SHELLY RICE OD PC INC SHELLY RICE O.D.

Name____________________________________ Age______ Birthdate____________
Primary Care Physician________________________ City______________ Phone__________
Preferred Pharmacy__________________________ Location___________ Phone__________
Date of last eye exam? _____________ Name of last eye physician?______________________

Current Medications (including non-prescription) ______________________________________

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Are you allergic to any medications? ☐ No ☐ Yes If yes, please list:______________________

Patient Social History:

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Use of Tobacco: ☐ Never ☐ Quit (date)____________ ☐ Current)packs per day___________

Family History: If yes, note the relationship to the patient.

☐ Glaucoma_________________________ ☐ High Blood Pressure______________________
☐ Diabetes__________________________ ☐ Macular Degeneration______________________

Past Medical History:

☐ Thyroid Disease ☐ High Blood Pressure ☐ HIV ☐ Diabetes: ☐ Insulin ☐ Non-Insulin
☐ Heart Disease ☐ Hepatitis Type____ ☐ TB Last Blood Sugar_____ Last A1C____
☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts
☐ Other____________________________________
☐ Eye Injuries please list____

Review of Systems: Do you have any of the following?

Gastrointestinal
☐ Heartburn/Reflux
☐ Nausea/Vomiting/Diarrhea

Neurologic/Head
☐ Headaches/migraines
☐ Weakness

Genitourinary
☐ Leaking Urine
☐ Bloody Urine

Skin
☐ Rash

Ears/Nose/Throat/Mouth/Neck
☐ Hay Fever/allergies/congestion
☐ Sinusitis
☐ Neck Problems

Respiratory
☐ Cough/wheeze
☐ Shortness of breath

Psychiatric
☐ Anxiety/Stress
☐ Depression
☐ Psychiatric Illness

Cardiovascular
☐ Chest pains/Discomfort
☐ Palpitations

Endocrine
☐ Thyroid Dysfunction
☐ Hormone Dysfunction

Blood/Lymphatic
☐ Blood Disease
☐ Unexplained lumps

Allergic/Immunologic
☐ Rheumatoid Arthritis
☐ Lupus

Musculoskeletal
☐ Muscle/joint pain
☐ Swollen joints

Constitutional
☐ Weight loss
☐ Fever

Are you pregnant or nursing? ☐ No ☐ Yes If yes, please give due/delivery date:_______________

EYES: ☐ Tearing ☐ Dryness ☐ Irritation ☐ Itching ☐ Blurred Vision ☐ Wear glasses ☐ Wear contact lenses

Social Occupational History: List any special vision needs:_____________________________

Have you had any of the following eye surgeries?

☐ Cataract ☐ Yag Laser ☐ Corneal ☐ ICL ☐ RLE ☐ RK ☐ Lasik ☐ PRK If yes year done?_______
By Dr.________________________________

List any surgeries or medical conditions not listed above:_________________________________

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Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

____ ____________
Patient, Parent or Legal Guardian's Signature If patient is under 18 years of age) Date