SANTA MONICA EYE MEDICAL GROUP
PATIENT MEDICAL HISTORY

Patient Name: _____ **Date**_____

1. Overall Health

Date of your last physical exam? _____

Please rate your health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has there been a change in your health in the past year? ☐ Yes ☐ No

If yes, please describe _____

_____

Have you had any serious illness past five years? ☐ Yes ☐ No

If yes, please describe _____

Have you ever had **any** kind of surgery (incl. eyes and all other types of surgery) ☐ Yes ☐ No

If yes, please describe _____

2. Drug Allergies - Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list: _____

3. Medications - Please list any medications you are taking (including non-prescription medications).

Name of Medication	Dosage (mg)	Frequency (times per day)

☐ If you need more lines to list medications check here and notify the technician during your appointment.

4. Review of Health: Do you have or have you ever had? (check yes/no)

☐ Yes ☐ No Diabetes Circle: Type I Type II

☐ Yes ☐ No High Blood Pressure

☐ Yes ☐ No High Cholesterol

☐ Yes ☐ No Heart Diseased/Stroke Describe _____

☐ Yes ☐ No Bleeding Disorder Describe _____

☐ Yes ☐ No Headache/Dizziness Describe _____

☐ Yes ☐ No Hearing Problems Describe _____

☐ Yes ☐ No Cancer Type/Grade _____

☐ Yes ☐ No Autoimmune Disease (e.g. Multiple Sclerosis, Rheumatoid Arthritis, Lupus, Sarcoidosis, etc.)

Describe _____

☐ Yes ☐ No Other Serious or Ongoing Health Issues

Describe _____

5. Eye Health

Date of your last dilated eye exam? _____ Date of you last vision exam for glasses/contacts? _____

☐ Yes ☐ No Do you wear glasses?

☐ Yes ☐ No Do you wear contact lenses?

Right Eye: Brand _____ Rx _____ B.C. _

Left Eye: Brand _____ Rx _____ B.C. _

Have you experienced any of following eye symptoms? (circle all that apply)

Burning Dryness Gritty Feeling Itching Watering Floaters Flashing Lights Light Sensitivity

Have you ever had any eye problems, diseases or surgeries? (check yes/no)

☐ Yes ☐ No Eye Injury Describe _____

☐ Yes ☐ No Blindness Describe _____

☐ Yes ☐ No Cataracts Describe _____

☐ Yes ☐ No Glaucoma Describe _____

☐ Yes ☐ No Retinal Describe _____

☐ Yes ☐ No Macular Degeneration Describe _____

☐ Yes ☐ No Double Vision Describe _____

☐ Yes ☐ No Amblyopia (Lazy Eye) Describe _____

☐ Yes ☐ No Strabismus (Crossed Eyes) Describe _____

☐ Yes ☐ No Eyelid Problems Describe _____

☐ Yes ☐ No Other Eye Problems Describe _____

6. Review of Social Habits: Do you use? (check yes/no)

☐ Yes ☐ No Tobacco Specify quantity and frequency: _____

☐ Yes ☐ No Alcohol Specify quantity and frequency: _____

☐ Yes ☐ No Other recreational substances

Specify, type, quantity and frequency: _____

7. Family History and Relationship (father/mother/sister/brother,etc):

☐ Yes ☐ No Blindness Relationship _____

☐ Yes ☐ No Cataracts Relationship _____

☐ Yes ☐ No Glaucoma Relationship _____

☐ Yes ☐ No Retinal Relationship _____

☐ Yes ☐ No Macular Degeneration Relationship _____

☐ Yes ☐ No Other Eye Problems Relationship _____

☐ Yes ☐ No Diabetes Relationship _____

☐ Yes ☐ No Heart Disease Relationship _____

☐ Yes ☐ No Bleeding Disorders Relationship _____