THURMOND EYE CENTER

Patient Medical History

Name:	DOB:	Age:	Date:
Race: □Caucasian □African American □Hispanic □Asian	Family Medical Doctor:		
Last Eye Exam:	Last Eye Doctor:		
Occupation:	Hobbies:		

Past Medical, Family, Social and Ocular History

Medical History / Review of Systems			Ocular History		
Self		Family	Self		Family
	Arthritis			Cataracts	
	Blood disease (anemia, sickle cell)			Glaucoma	
	Ear, Nose, Throat (allergies)			Macular Degeneration	
	GI Disease (ulcers, acid reflux, Crohns)			Blindness	
	Thyroid Disease			Lazy Eye/Eye Turn	
	Lung Disease (asthma, emphysema)			Retinal Disorders	
	Heart Disease			Eye Injuries	N/A
	Kidney, Bladder, Genital			Eye Surgeries	
	Diabetes (sugar)			*Other (list)*	
	High Blood Pressure		**Social History**		
	Neurological Problems (brain, nerves)		Marital Status: □Single □Married □Divorced/Widowed		
	Skin Disease		Do you live alone? □YES □NO □Assisted Living Fac.		
	Mental (depression, anxiety)		Do you smoke/use forms of Tobacco? □YES □NO		
	Cancer		If yes, how much/often?		
	Infectious Disease (HIV, hepatitis)		Do you drink Alcohol? □YES □NO		
	Other (list)		If yes, how much/often?		
Medications:			**Drug Allergies:**		

Patient Initials / Date	Tech Initials / Date	Dr. Initials / Date

Are you pregnant? □YES □NO