PAJKA EYE CENTER

NAME_____**DATE**_____

MEDICAL HISTORY

ARE YOU BEING TREATED FOR:

YES	NO	
☐	☐	DIABETES…….HOW LONG _____
☐	☐	HIGH BLOOD PRESSURE
☐	☐	HEART DISEASE OR HEART ATTACK
☐	☐	ASTHMA,COPD,SHORTNESS OF BREATH
☐	☐	STROKE
☐	☐	KIDNEY STONES
☐	☐	THYROID
☐	☐	CANCER
☐	☐	LUPUS, RHEUMATOID ARTHRITIS
☐	☐	HIGH CHOLESTEROL
☐	☐	MRSA
☐	☐	HIV/AIDS
☐	☐	HEPATITIS

OTHER_____

_____

FAMILY/SOCIAL HISTORY

- ☐ Blindness Mom/Dad/Brother/Sister
- ☐ Glaucoma Mom/Dad/Brother/Sister
- ☐ Diabetes Mom/Dad/Brother/Sister
- ☐ Heart Mom/Dad/Brother/Sister
- ☐ Cancer Mom/Dad/Brother/Sister
- ☐ Stroke Mom/Dad/Brother/Sister
- ☐ Arthritis Mom/Dad/Brother/Sister
- ☐ Other_____

Do you drink alcohol?

NO ___ Occasionally
___1-2 per day
___3+ per day

Do you smoke?

NO ___1/2 pk per day
___1 pk per day
___1+ pk per day

REVIEW OF SYSTEMS

Pregnant or nursing	☐ YES ☐ NO	_____
Fever /weight loss	☐ YES ☐ NO	_____
Ears, nose throat	☐ YES ☐ NO	_____
Heart	☐ YES ☐ NO	_____
Stomach, Bowel	☐ YES ☐ NO	_____
Respiratory (asthma, emphysema, COPD etc)	☐ YES ☐ NO	_____
Genital/Kidney HISTORY OF FLOMAX	☐ YES ☐ NO	_____
Skin	☐ YES ☐ NO	_____
Muscle, Joints, Bone	☐ YES ☐ NO	_____
Neurological (MS, stroke, etc)	☐ YES ☐ NO	_____
Psychiatric (depression, anxiety etc)	☐ YES ☐ NO	_____
Endocrine (diabetes, thyroid etc)	☐ YES ☐ NO	_____
Allergy/Immune System	☐ YES ☐ NO	_____
Blood/Lymph (cholesterol, anemia etc)	☐ YES ☐ NO	_____

Other_____

SURGICAL HISTORY

____Cataract Surgery Right Left Both Date_____ By_____
___ Lasers Right Left Both Date_____ By_____

LIST ANY OTHER SURGERIES:

_____Date_____
_____Date_____
_____Date_____
_____Date_____
_____Date_____
_____Date_____
_____Date_____
_____Date_____
_____Date_____
_____Date_____
_____Date_____

FOR OFFICE USE:
UPDATED
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PAJKA EYE CENTER

NAME____DATE________________

MEDICATION ALLERGIES:

NAME **TYPE OF REACTION** : rash, hives, breathing, etc

____

____

____

____

____

ANY ALLERGIES TO:

LATEX YES NO

If yes, explain_____________

____

IODINE YES NO

If yes, explain_____________

____

PLEASE LIST ANY MEDICATIONS YOU TAKE, INCLUDE VITAMINS, HERBS AND EYE DROPS:

*******FOR OFFICE USE ONLY********

NAME	MGS	X PER DAY						