Indianapolis Eye Care Center **Patient Medical History Record**

Indiana University School of Optometry
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Today's Date ________/________/________

In an effort to better serve our patients, we ask that you complete this form as accurately as possible. Please answer all questions. Thank you.

Name: ________________________________**Date of Birth** _____/_____/_____**Social Security #** ________________
Occupation: ____ **Medical Doctor:**____________________________________

Allergies: List all known allergies

Penicillin: Yes No	Sulfa: Yes No		Seasonal: Yes No	What time of year?
Iodine: Yes No	Pain med Yes No Type:		Other Allergies:	

Medications: Please list below (or provide a list of) all medications, including eye drops & non-prescription drugs.

Review of Systems:

Do you currently have any of the following problems? Yes No If YES, please explain:

Heart Problems (chest pain, irregular heart beat) ______________________________
Respiratory Problems (shortness of breath, wheezing, cough) ______________________________
Gastrointestinal Problems (heartburn, abdominal pain, diarrhea) ______________________________
Urinary Problems (pain or discomfort, blood in urine) ______________________________
Skin Problems (rashes, excessive dryness, rosacea) ______________________________
Musculoskeletal Problems (muscle aches, joint pain, swollen joints) ______________________________
Neurologic Problems (numbness, weakness, headaches, paralysis) ______________________________
Psychiatric Problems (depression, anxiety) ______________________________
Chronic fever, unexpected weight loss/gain, fatigue ______________________________
Ear/nose/throat Problems (hearing loss, sinus problems, sore throat) ______________________________
Endocrine Problems (diabetes, thyroid problems) ______________________________

Have you or immediate family member (parent, grandparent, sibling) ever had any of the following conditions?

	Self/Family		Self/Family		Self/Family		Self/Family
Cataract	___/___	Blindness	___/___	Diabetes	___/___	Migraines	___/___
Glaucoma	___/___	High Blood Pressure	___/___	Asthma	___/___	Seizures/Epilepsy	___/___
Eye Injury	___/___	Heart Disease	___/___	Chronic Bronchitis	___/N/A	Arthritis	___/___
Crossed/Lazy Eye	___/___	Stroke	___/___	Sinus Problems	___/N/A	Thyroid Disease	___/___
Retinal Detachment	___/___	Heart arrhythmia	___/___	Tuberculosis	___/N/A	Cancer	___/___
Retinal Degeneration	___/___	Anemia	___/___	HIV/AIDS	___/N/A	Liver disease	___/N/A
Macular Degeneration	___/___	Bleeding Problems	___/___	High Cholesterol	___/___		

Surgeries: List any previous surgeries, including eye surgeries and laser procedures:

Do you smoke? Yes No If Yes, how much______ Do you drink alcohol? Yes No If Yes, how much_______

Are you using recreational (including IV) drugs? Yes No If Yes, what? ______________________

PATIENT OR GUARDIAN SIGNATURE____________________________

DATE	INTERN'S INITIALS	DOCTOR'S INITIALS
___________	___________	___________
___________	___________	___________
___________	___________	___________