Universal Eye Center, PA **MEDICAL HISTORY AND REVIEW OF SYSTEMS**

Patient Name____Date of Birth____________________

Please answer the following questions about your medical history:

Have you ever been treated for any of the following conditions:

❑ Diabetes (list what type) ❑ High Blood Pressure ❑ Heart Disease
❑ Lung disease ❑ Thyroid Dysfunction ❑ Arthritis
❑ Cancer ❑ Glaucoma ❑ Macular Degeneration
❑ Dry Eye ❑ Strabismus ❑ Retinal Detachment
❑ Cataract
❑**Other**____

Have you had any type of surgery? (Including medical and/or eye):

❑ Cataract ❑ Glaucoma ❑ Laser
❑ Cosmetic ❑ Retinal ❑ Eye Muscle
❑ Refractive ❑ **Other** (please specify what year)____________

Do any medical or eye diseases run in your family?

❑ Diabetes ❑ High Blood Pressure ❑ Heart disease
❑ Heart attack ❑ Arthritis ❑ Blindness
❑ Cancer ❑ Cataract ❑ Glaucoma
❑Macular Degeneration ❑ Retinal Detachment ❑ Other

Please which list family member "mother, father, etc.":____

Do you have any of the following? (ROS) :

❑ Rashes ❑ Excessive Dryness ❑ Hearing loss ❑ Sinus problems
❑ Sore Throat ❑ Chest pain ❑ Irregular hear beat ❑ Shortness of breat
❑ Wheezing ❑ Coughing ❑ Unexpected weight loss/gain ❑ Diarrhea
❑ Fatigue ❑ Heartburn ❑ Abdominal pain ❑ Swollen joints
❑ Vomiting ❑ Muscle aches ❑ Joint pain ❑ Depression
❑ Numbness ❑ Weakness ❑ Paralysis
❑ Anxiety ❑ None

Other____________________________________

Are you currently having and of the following problems? (chief complaint)

❑ Blurry Vision ❑ Floaters (black spots in your vision) ❑ Flashes of light
❑ Burning ❑ Irritation ❑ Headaches ❑ Decreased Vision
❑ Redness ❑ Itchiness ❑ Pain ❑ Loss of Vision right eye/left eye/both
❑ Photophobia (light sensitivity) ❑**Other**______________________________

Are you allergic to any medications____

Please list the affect this had on you:____

Do you smoke? If so, how many packs a day?______
Do you drink? If so, how much per week?______

Please list medications (prescription/over-counter): (name, dose, how often you take it)

Please list eye drops/ointments (prescription/over-the-counter) you use:(name, dose and how often you use it)

Doctor Signature____Date__________________