



## Island Eye Physicians & Surgeons Medical History

Name:	Birthday:	Date:
Address:	Phone:	Age:
Occupation:	Referred By:	
Primary Care Physician:		
What concerns do you have about your vision or eyes?		
What eye diseases or problems have you had in the past?		
What medical problems or surgery do you have?		
Please list the medications, vitamins and supplements you take:		
What medical or eye problems do your family members have?		
What drug allergies do you have?		
Do you smoke?		

Do you currently have any problems involving:	No	Yes (Please explain)
Fever or weight loss/gain or fatigue		
Ear/nose/throat (e.g. hearing loss, sore throat)		
Heart (e.g. chest pain, irregular heart beat)		
Respiratory (e.g. shortness of breath, wheezing)		
Gastrointestinal ( e.g. abdominal pain, vomiting)		
Urinary (e.g. blood in urine)		
Skin (e.g. rash)		
Blood (e.g. anemia, high cholesterol)		
Musculoskeletal (e.g. muscle aches, joint pain)		
Neurologic (e.g. numbness, weakness, headaches )		
Psychiatric (e.g. depression, anxiety)		

Patient Signature:

Reviewed by Physician:

Date: