HIGHLAND CLINIC
Ophthalmology

Date:_____

Patient Name:_____ Primary Care Physician:_____

MEDICAL INFORMATION SHEET*(FAX TO 4451)*

1. Past Medical History: *Do you have?*

- ☐ Asthma
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Arthritis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ Other _____

_____

2. Past Eye Surgeries or Laser Surgery History:

- ☐ Cataract Surgery Date: _____
- ☐ Glaucoma Surgery Date: _____
- ☐ Retina Surgery Date: _____
- ☐ Other_____

3. Eye Diseases *list any you have?*

_____

4. Drug Allergies:_____

5. Medications: *Drug Name/Dose/Strength How you take it (for example, once a day, twice a day, etc)*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

6. **Family History of Eye Diseases and relationship (father/mother/sister/brother,etc):**

- ☐ Glaucoma _____
- ☐ Cataracts _____
- ☐ Retinal _____
- ☐ Blindness_____
- ☐ None
- ☐ Other_____

7. Review of Systems: ***Do you have? (circle all that apply)***

SKIN: itching, rash, ulcer, tumors (growths), other ☐ Yes ☐ No
LYMPH NODES: swelling, tenderness, other ☐ Yes ☐ No
BONES, JOINTS, MUSCLES: muscle pain/cramps, joint pain, swelling,other ☐ Yes ☐ No
ENDOCRINE (eg. Thyroid) fatigue, confusion, fainting, nervousness, hot/cold intolerance/hair loss, other ☐ Yes ☐ No
ALLERGY/IMMUNOLOGY: recurrent infections, hayfever, hives, food allergy, drug sensitivity, other ☐ Yes ☐ No
HEAD: headaches, dizziness, vertigo, other ☐ Yes ☐ No
EARS: hearing loss, ringing, infections, other ☐ Yes ☐ No
NOSE: bleeding, loss of smell, congestion, sinus problems, other ☐ Yes ☐ No
THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, other ☐ Yes ☐ No
NECK: pain, swelling, stiffness, other ☐ Yes ☐ No
BREASTS: tenderness, swelling, lumps, discharge, other ☐ Yes ☐ No
BLOOD: bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other ☐ Yes ☐ No
RESPIRATORY: wheezing, cough(productive/blood), difficulty breathing, asthma, Other ☐ Yes ☐ No
CARDIOVASCULAR (heart/blood vessels): chest pain, swelling of extremities, shortness of breath, exercise intolerance, etc ☐ Yes ☐ No
GASTROINTESTINAL (stomach/intestines): nausea, vomiting, change in bowel habits, constipation, diarrhea, pain/cramps, bleeding, other ☐ Yes ☐ No
GENITOURNIARY (kidney/bladder): frequency, burning, hesitancy, pain or bleeding on urination, infections, incontinence, impotence, etc ☐ Yes ☐ No
NERVOUS SYSTEM: weakness in arms or legs, numbness or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other ☐ Yes ☐ No
PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations, other ☐ Yes ☐ No