CREEKSIDE
VISION & HEARING

# MEDICAL HISTORY

Name: _____ Date of Birth:_____ Date:_____
Occupation: _____ ☐ Male ☐ Female
Primary Care Physician: _____ Referring Physician: _____

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Please list allergies / reactions to medication or food: None ☐

_____

_____

Please list all medication you are currently taking (including eyedrops, over-the-counter medications, vitamins, etc.) None ☐

_____

_____

Have you ever been treated for any medical conditions:

| | Yes | No | Comments/Description |
|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | _____ |
| Heart Disease or Problems | ☐ | ☐ | _____ |
| Allergy or Hay Fever | ☐ | ☐ | _____ |
| Asthma or Lung disease | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | _____ |
| Thyroid Disease | ☐ | ☐ | _____ |
| Arthritis | ☐ | ☐ | _____ |
| Cancer | ☐ | ☐ | _____ |
| Other serious / chronic illness | ☐ | ☐ | _____ |

Do any medical or eye diseases run **in your family**? Please list their relationship to you (uncle, sister, etc.)

| | | | | | |
|---|---|---|---|---|---|
| Diabetes | ☐ Yes ☐ No _____ | Glaucoma | ☐ Yes ☐ No _____ |
| High Blood Pressure | ☐ Yes ☐ No _____ | Cataracts | ☐ Yes ☐ No _____ |
| Allergy | ☐ Yes ☐ No _____ | Crossed / lazy eyes | ☐ Yes ☐ No _____ |
| Asthma | ☐ Yes ☐ No _____ | Macular Degeneration | ☐ Yes ☐ No _____ |
| Cancer | ☐ Yes ☐ No _____ | Retinal Detachment | ☐ Yes ☐ No _____ |
| Bleeding problems | ☐ Yes ☐ No _____ | Blindness | ☐ Yes ☐ No _____ |

Please list all past surgeries and approximate dates: None ☐

_____

_____

_____

Please list all hospitalizations and approximate dates: None ☐

_____

_____

Tobacco use: ☐ Current ☐ Former ☐ Never How much and for how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

**PLEASE CONTINUE ON REVERSE**

Do you **currently** have any of the following problems: If yes, circle problem(s) or describe

| | Yes | No | If yes, explain: |
|---|---|---|---|
| Fever(s), unexpected weight loss / gain, fatigue | ☐ | ☐ | _____ |
| Allergic Problems (*hay fever, sneezing, hives, etc)* | ☐ | ☐ | _____ |
| Heart problems (*chest pain, murmurs, irregular heart beat*) | ☐ | ☐ | _____ |
| Respiratory problems (*shortness of breath, wheezing, coughing*) | ☐ | ☐ | _____ |
| Gastrointestinal problems (*heartburn, abdominal pain, diarrhea, vomiting*) | ☐ | ☐ | _____ |
| Urinary problems (*pain or discomfort, blood in urine*) | ☐ | ☐ | _____ |
| Skin problems (*rashes, eczema, excessive dryness, acne*) | ☐ | ☐ | _____ |
| Musculoskeletal problems (*muscle aches, joint pain, swollen joints)* | ☐ | ☐ | _____ |
| Neurologic problems (*numbness, weakness, headaches, paralysis*) | ☐ | ☐ | _____ |
| Psychiatric problems (*depression, anxiety*) | ☐ | ☐ | _____ |

***For Eye Visits Only***

| Have you experienced any: | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Blurred vision | ☐ | ☐ | Do you wear glasses? | ☐ | ☐ |
| Floaters or flashes of light | ☐ | ☐ | Do you wear contact lenses? | ☐ | ☐ |
| Redness of eyes | ☐ | ☐ | Type: _____ | | |
| Irritation or itching of eyes | ☐ | ☐ | | | |
| Discharge from eyes | ☐ | ☐ | | | |

Please list any past or present eye diseases, infections, injuries or surgeries: None ☐

_____

_____

***For Hearing Visits Only***

| Have you experienced any: | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Loud noise exposure at work or home | ☐ | ☐ | Hearing Loss | ☐ | ☐ |
| Any ringing or buzzing in the ears | ☐ | ☐ | Do you wear hearing aids | ☐ | ☐ |
| Have you ever worn a hearing aid | ☐ | ☐ | | | |

Comments:

_____

_____

_____

The above was reviewed with the patient: _____ Date:_____