MISSISSIPPI EYE ASSOCIATES

MEDICAL HISTORY

Name: ____________________________________ **Chart#:** _________________

Date: _____/______/_______

Check if you have/had problems with any of the following:

____ Lazy Eye
____ Corneal Disease
____ Blurry Vision
____ Muscle Surgery
____ Glaucoma
____ Red Eyes
____ Cataract
____ Chronic Eye Infection
____ Double Vision
____ Retinal Problems
____ Sty/Lid Infections
____ Eye Pain
____ Macular Degeneration
____ Dry Eyes
____ Mucous/Drainage
____ Corneal Transplant
____ Tearing

List any eye surgeries or injuries that you have had:

TYPE OF SURGERY/INJURY	TREATING PHYSICIAN	DATE

Do you wear glasses? ___Yes ___ No Do you wear Contact Lenses? ___ Yes ___ No
Date of last exam: _____/______/______
Do you have a family history of: ____ Diabetes ____ Glaucoma ____ Macular Degeneration ____ Other ____
Have you tested positive for HIV? ____ Yes ____ No
Do you smoke now? ________ Have you ever smoked? _______ How long? _____
Are you allergic to any medicines? _____ No _____ Yes If yes, please list: _________________
____

Name of your family doctor: ____

Review of Systems (Please check if you have/had problems with the following):

____ Diabetes
____ Skin Disorders
____ Thyroid Disorder
____ High Blood Pressure
____ Neurological Disorders
____ Fever/Weight Loss
____ Heart Attack
____ Allergy/Immune System
____ Ear/ Nose/ Throat
____ Stroke
____ Blood Disorders
____ Gastrointestinal

List any major surgeries that you have had: ____
____

List all medications you are currently taking, including eye drops:

MEDICATION	DOSAGE	FREQUENCY	INDICATION