MAYNOR & MITCHELL EYE CENTER

Patient Health History

HLC HUNTSVILLE LASER CENTER
A Division of Maynor & Mitchell Eye Center

Today's Date:_____

Patient Name:_____Date of Birth:_____

Occupation:_____Referring Doctor: _____

Reason for today's visit_____

Most recent eye doctor:_____ Primary care physician:_____

Date of last eye exam:_____Date of last medical exam:_____

Y / N Do you wear glasses/contacts/both? *(circle)* If wearing contacts, are they soft/hard? *(circle)*

Do you have or have previously been treated for (If so, please describe):

Y / N Cataract_____
Y / N Glaucoma_____
Y / N Macular Degeneration_____
Y / N Eye Injury_____
Y / N Dry Eyes_____
Y / N Diabetes:_____years
Controlled by: Diet/Pills/Insulin *(circle)*
Y / N High Blood Pressure:_____years
Y / N Heart Attack/Heart Disease_____
Y / N Kidney Disease_____
Y / N Liver Disease_____
Y / N Stroke_____

Y / N Cornea Disease_____
Y / N Retinal Tear/Detachment_____
Y / N Diabetic Eye Disease_____
Y / N Crossed Eyes/Lazy Eye_____
Y / N Other_____
Y / N Cancer_____
Y / N HIV/AIDS_____
Y / N Abnormal Bleeding_____
Y / N Arthritis_____
Y / N Gastrointestinal Problems_____
Y / N Are you pregnant/breastfeeding? Due date_____
Y / N Other_____

Y / N Surgeries (please list with dates, doctor) _____

_____

_____

Current Medications and Dosages	
1	5
2	6
3	7
4	8

Y / N Are you allergic to any medications? If yes, please list:_____

Has anyone in your family had any of the following? If yes, please list relationship .

Y / N Cataract_____ Y / N Macular Degeneration_____

Y / N Retinal Tear/Detachment_____ Y / N Diabetes_____

Y / N Glaucoma_____ Y / N Corneal Disease_____

Y / N Crossed Eyes/Lazy Eye_____ Y / N Other_____

Social History

Y / N Never Smoker

Y / N Former Smoker: Quit date_____

Y / N Current Smoker: _____ packs/day

Y / N Alcohol Use

If yes: Y / N 3 or less drinks per week

Y / N 4 or more drinks per week

Review of Systems

Are you currently experiencing any problems:	Yes	No	Details
Constitution (Weight gain, loss of appetite, other)			
Cardiovascular (Chest pain, irregular rhythm, other)			
Ear, Nose, Mouth, Throat *(Dry mouth, sore throat, runny nose, earache, other)*			
Respiratory (Shortness of breath, wheezing, cough, other)			
Gastrointestinal (Constipation, diarrhea, acid reflux, other)			
Genitourinary (Painful urination, incontinence, other)			
Musculoskeletal (Joint pain, muscle ache, joint swelling, other)			
Integumentary (Skin rash, itching, other)			
Neurological (Headache, dizziness, other)			
Psychiatric (Anxiety, depression, other)			
Endocrine (Frequent urination, frequent thirst, always hot or cold, other)			
Hematologic/Lymphatic (Anemia, excessive bleeding, other)			
Allergic/Immunologic (Hay fever, itchy eyes, other)			