

Date: _____

Patient Name: _____ Birth date: _____

Primary Care Physician: _____



GREEN EYE INSTITUTE

102 East Hospital Drive
Hattiesburg, MS 39402
(601) 268-5144

PERSONAL MEDICAL HISTORY

Do **you** now have, or have ever you had any of the following conditions (check all that apply):

Are you allergic to any medicine? Yes No

List:

- High Blood Pressure
- Heart Conditions/Heart Attack/Angina
- Elevated Cholesterol/Triglycerides
- Diabetes How long? _____
- Respiratory Conditions/Asthma/TB/Emphysema/COPD
- Stroke/Numbness/Paralysis/Seizures/Headaches
- Kidney/Bladder/Prostate Conditions/Stones
- Chronic Illness (Cancer, HIV, Hepatitis)
- Arthritis/Joint Replacement/Gout
- Ear, Nose, Throat Conditions/Sinus/Allergies
- Digestive/Acid Reflux/Ulcers
- Rash/Skin Cancer/Melanoma
- Memory Loss/Confusion/Alzheimer's
- Anxiety/Depression/ADD/ADHD
- Thyroid Condition
- Bleeding-Bruising Tendencies/Anemia
- Sexually Transmitted Diseases
- Other:
- Surgeries:
- None of the Above

- Eye Injury
- Eye Operation/Laser Procedure
- "Crossed" Eyes
- Glaucoma
- Cataracts
- Macular Degeneration
- Other Retinal Conditions
- Chalazion (Stye)
- Corneal Conditions/Transplant
- Chronic Eye Infection(s)
- Amblyopia (Lazy Eye)
- Dry Eye Syndrome
- Pingueculum/Pterygium
- None of the Above

OPTICAL HISTORY

Do **you** now, or have you ever (check all that apply):

- Worn Glasses
- Worn Contact Lenses

SOCIAL HISTORY

Do **you** now (check all that apply):

- Smoke
- Use Alcohol

EYE MEDICATIONS

List any **prescription** or "**over-the-counter**" **EYE** medications? None

1. _____
2. _____
3. _____
4. _____
5. _____

Do **you** take Aspirin? Yes No

OTHER MEDICATIONS

List other medications **you** are taking and the purpose of each: None

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FAMILY HISTORY

List family members (**parents, siblings, children**) who have or have had any of the following conditions:

- Glaucoma
- Cataracts
- Macular Degeneration
- Other Retinal Conditions
- Corneal Conditions
- Amblyopia (Lazy Eye)
- "Crossed" Eyes
- Other Eye Conditions
- Unknown
- Blindness or near blindness due to causes other than an accident
- High Blood Pressure
- Heart Conditions/Heart Attack/Stroke
- Diabetes
- Respiratory Conditions/Asthma/TB
- Bleeding Tendencies
- Unknown

For Pediatric Patients (under age 18):

- Pregnancy Normal: Yes No Term Premature
- Delivery: Spontaneous Forceps Cesarean
- Immunizations Current (DPT, Polio, MMR, HIB)? Yes No
- Childhood Illnesses:
- Measles Mumps Chicken Pox Rubella

Review:

1. O.A. _____ M.D. _____ Date _____
2. O.A. _____ M.D. _____ Date _____
- Noted Changes: _____
3. O.A. _____ M.D. _____ Date _____
- Noted Changes: _____