TALLEY MEDICAL-SURGICAL EYE CARE ASSOCIATES

MEDICAL HISTORY RECORD

www.talleyeyecare.com

Height: _____

Weight: _____

Name: _____ **Today's Date:** ____/____/____ **Birthdate:** ____/____/____ **Age:** _____

Address: _____ **E-Mail:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____ **Sex:** ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed **Social Security No.:** _____

Race: ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Language Preference: ☐ English ☐ Spanish ☐ Other _____

Employer: _____ **Work Phone:** _____

Notify in case of emergency: _____ **Phone:** _____ **Relationship:** _____

Family Doctor: _____ Phone: _____ Date of last doctor visit: ____/____/____

Referring Doctor: _____ Phone: _____

Is this a Workers' Comp injury? ☐ Yes ☐ No If YES, what is the nature of the injury? _____

Date of Injury: ____/____/____ Has the accident been reported to your employer? ☐ Yes ☐ No

Employer Name: _____ Employer Address: _____

Employer Phone: _____ Contact Person: _____

Is this an Auto Liability Accident injury? ☐ Yes ☐ No If YES, what is the nature of the injury? _____

Where were you when injury/accident occurred? _____

What were you doing when injury/accident took place? _____

Auto Insurance Company Name: _____ Phone: _____

Contact Person: _____ Claim Number (if known): _____

RESPONSIBLE PARTY'S INFORMATION (if a Minor, Guardian or Power of Attorney)

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

Date of Birth: ____/____/____ Social Security No.: _____

PRIMARY INSURANCE INFORMATION

Name of Insurance: _____ Name of Cardholder: _____

ID#: _____ Cardholder's Social Security No.: _____ Cardholder's Birthdate ____/____/____

Relationship to patient: _____ Cardholder's Employer: _____

SECONDARY INSURANCE INFORMATION

Name of Insurance: _____ Name of Cardholder: _____

ID#: _____ Cardholder's Social Security No.: _____ Cardholder's Birthdate ____/____/____

Relationship to patient: _____ Cardholder's Employer: _____

PRESENT ILLNESS

Do you currently have any problems in the following areas?

	YES	NO		YES	NO		YES	NO
EYES								
Blurred vision	☐	☐	Excessive tearing/watering	☐	☐	Are you having any difficulty?		
Loss of vision	☐	☐	Infection of eye/eyelid	☐	☐	Reading small print	☐	☐
Double vision	☐	☐	Dryness	☐	☐	Driving at night	☐	☐
Fluctuating vision	☐	☐	Redness	☐	☐	Halos around headlights	☐	☐
Glare/light sensitive	☐	☐	Itching	☐	☐	Reading traffic lights	☐	☐
Mucous discharge	☐	☐	Eye pain/soreness	☐	☐	Doing hobbies	☐	☐
Eye irritation	☐	☐	Stye, chalazion	☐	☐	Watching TV	☐	☐

REVIEW OF SYSTEMS / PAST MEDICAL HISTORY

Are you currently having any problems in the following areas OR ever been treated for?

	CURRENT	PAST
Constitutional		
childbirth	☐	☐
fever	☐	☐
obesity	☐	☐
Integumentary (Skin)		
breast cancer	☐	☐
skin cancer	☐	☐
Musculoskeletal		
muscle/joint pain	☐	☐
lupus	☐	☐
osteoarthritis	☐	☐
rheumatoid arthritis	☐	☐
Ears, Nose, Throat		
difficulty hearing	☐	☐
ear pain	☐	☐
nasal congestion	☐	☐
nasal bleeding	☐	☐
chronic cough	☐	☐
dry throat/mouth	☐	☐
Allergic/Immunologic		
hay fever symptoms	☐	☐
immune problems	☐	☐
seasonal allergies	☐	☐

	CURRENT	PAST
Gastrointestinal		
gastric reflux/GERD	☐	☐
colon cancer	☐	☐
stomach ulcers	☐	☐
nausea/vomiting	☐	☐
Genitourinary		
cervical cancer	☐	☐
uterine cancer	☐	☐
kidney disease	☐	☐
prostate cancer	☐	☐
prostate hypertrophy	☐	☐
Neurological		
migraines	☐	☐
Alzheimer's	☐	☐
seizure disorder	☐	☐
stroke/CVA	☐	☐
Cardiovascular		
high blood pressure	☐	☐
congestive heart failure	☐	☐
heart attack	☐	☐
heart disease	☐	☐
high cholesterol	☐	☐
irregular heart beat	☐	☐

	CURRENT	PAST
Respiratory		
asthma	☐	☐
COPD	☐	☐
emphysema	☐	☐
lung cancer	☐	☐
sarcoidosis	☐	☐
Endocrine		
diabetes	☐	☐
pancreatic cancer	☐	☐
thyroid cancer	☐	☐
thyroid problems	☐	☐
weight loss	☐	☐
weight gain	☐	☐
Hematologic/Lymphatic		
anemia	☐	☐
bleeding disorder	☐	☐
blood cancer	☐	☐
leukemia	☐	☐
sickle cell disease	☐	☐
Psychiatric		
anxiety	☐	☐
depression	☐	☐
dementia	☐	☐

Other Past/Present Conditions: _____

PAST OCULAR HISTORY

- ☐ No significant illnesses
- ☐ Bell's palsy
- ☐ cataract
- ☐ chalazion/stye
- ☐ corneal laceration/scratch
- ☐ corneal ulcer
- ☐ diabetic retinopathy
- ☐ double vision
- ☐ dry eye syndrome
- ☐ eyelid turned inward
- ☐ eyelid turned outward
- ☐ foreign body removed
- ☐ Fuchs' dystrophy
- ☐ glaucoma
- ☐ herpes
- ☐ iritis
- ☐ lazy eye (amblyopia)
- ☐ macular degeneration
- ☐ nerve palsy
- ☐ ocular allergies
- ☐ pterygium
- ☐ retinal detachment
- ☐ uveitis
- ☐ Other _____

PAST OCULAR SURGERY

- ☐ No prior eye surgery
- ☐ cataract surgery
- ☐ corneal surgery
- ☐ eye muscle surgery
- ☐ eyelid surgery
- ☐ glaucoma surgery
- ☐ laser eye surgery
- ☐ LASIK/refractive surgery
- ☐ pterygium surgery
- ☐ retinal surgery
- ☐ Other _____

PAST INFECTION HISTORY

- ☐ None
- ☐ AIDS
- ☐ Chicken Pox
- ☐ Chlamydia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes Simplex
- ☐ Herpes Zoster
- ☐ Histoplasmosis
- ☐ HIV
- ☐ Rheumatic Fever
- ☐ STD
- ☐ Syphilis
- ☐ Tuberculosis
- ☐ Other _____

OTHER PAST SURGERY

- ☐ No prior surgery
- ☐ appendectomy
- ☐ back surgery
- ☐ brain surgery
- ☐ breast surgery
- ☐ carotid surgery
- ☐ colon surgery
- ☐ coronary artery bypass
- ☐ dental surgery
- ☐ gallbladder
- ☐ heart surgery
- ☐ hip surgery
- ☐ hysterectomy
- ☐ implanted defibrillator
- ☐ intestine surgery
- ☐ kidney surgery
- ☐ lung surgery
- ☐ lymph node surgery
- ☐ mastectomy
- ☐ nose surgery
- ☐ orthopedic surgery
- ☐ pacemaker
- ☐ stomach surgery
- ☐ thyroid surgery
- ☐ tonsillectomy
- ☐ tumor removed
- ☐ Other _____

FAMILY HISTORY

	YES	NO	RELATIONSHIP TO PATIENT
☐ blindness	☐	☐	_____
☐ heart attack	☐	☐	_____
☐ cataract	☐	☐	_____
☐ high blood pressure	☐	☐	_____
☐ glaucoma	☐	☐	_____
☐ heart problems	☐	☐	_____
☐ macular degeneration	☐	☐	_____

	YES	NO	RELATIONSHIP TO PATIENT
retinal detachment	☐	☐	_____
cancer	☐	☐	_____
stroke	☐	☐	_____
diabetes	☐	☐	_____
thyroid disease	☐	☐	_____
Fuchs' dystrophy	☐	☐	_____
Other _____	☐	☐	_____

SOCIAL HISTORY

	YES	NO	
Do you currently wear glasses?	☐	☐	How long have you had the current pair? ☐ weeks ☐ months ☐ years
Do you currently wear contacts?	☐	☐	What type of contacts? ☐ hard ☐ soft ☐ gas permeable
Have you ever tried to wear contacts?	☐	☐	
Do you drive?	☐	☐	
Do you drink alcohol?	☐	☐	
Do you use illegal drugs?	☐	☐	

Are you a ☐ current every day smoker How many packs per day? ________________

☐ former smoker When did you quit? ________________

☐ never smoker

What is your occupation? ____

If retired, what was your occupation? ____

MEDICATIONS

List all current medications you are taking (includes prescription, over-the-counter, herbals, vitamins, mineral supplements, dietary supplements). Attach a list if necessary.

Name:	Dosage:	How often?
By ☐ mouth ☐ inject ☐ patch ☐__________	Prescribing Doctor:	Taken for?
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By ☐ mouth ☐ inject ☐ patch ☐__________	Prescribing Doctor:	Taken for?
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Name:	Dosage:	How often?
By ☐ mouth ☐ inject ☐ patch ☐__________	Prescribing Doctor:	Taken for?

What pharmacy do you use? ____ pharmacy phone: ____________________________

Do you have allergies to any medications? ☐ Yes ☐ No

If YES, list medications and the reaction to them (includes difficulty breathing, confusion, cough, dizziness, swelling of limbs, headache, lethargy, nausea/vomiting, hives/rash)

____

____

Have you ever had a reaction to anesthetic? ☐ Yes ☐ No

Do you currently or have you ever used Flomax (Tamsulosin)? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

Do you have MRSA/VRE? ☐ Yes ☐ No

For Office Use Only: Reviewed ________ Date ___________ Reviewed ________ Date ___________ Reviewed ________ Date ___________

Reviewed ________ Date ___________ Reviewed ________ Date ___________ Reviewed ________ Date ___________

Reviewed ________ Date ___________ Reviewed ________ Date ___________ Reviewed ________ Date ___________