Putnam Vision Center **Patient Medical History** **Date: ___/____/ 2011**

General Status

Name of Primary Medical Doctor: ____________________ Doctor's Phone Number: (______) ______- _______

Last Visit to Primary Medical Doctor: ____/____/_____ Reason for last visit: __________________

Ocular/Eye History (If you are a current patient of the practice, please skip to patient current symptoms)

Last Eye Exam: _____/_____/_____ Last eye exam Doctor: ___________________
Do you wear glasses? __No ___Yes If yes, how old is your current pair of lenses? ______________
Do you wear contact lenses? __No __ Yes If yes, how old is your current pair of lenses? ______________
Current type of contact lenses: __Rigid __ Soft __ Extended Wear __ Other (please List): ______________
Are your contacts comfortable? __No __Yes
Have you ever had Lasik surgery? __No __ Yes If yes, where and when? _______________________________
Do you drive? __No __Yes If yes, do you have visual difficulty when driving? __No __Yes If yes, please describe: ___________
____

Patient Current Symptoms
Do you **currently** have problems in the following areas:

	No	Yes	?		No	Yes	?
Loss of Vision	__	__	__	Prominent eyes	__	__	__
Loss of Side Vision	__	__	__	Dryness	__	__	__
Distorted Vision/Halos	__	__	__	Double Vision	__	__	__
Mucous Discharge	__	__	__	Light Sensitivity/Glare	__	__	__
Sandy or Gritty Feeling	__	__	__	Lazy Eyes	__	__	__
Burning	__	__	__	Drooping eyelid	__	__	__
Foreign Body Sensation	__	__	__	Eye Infection	__	__	__
Excess Tearing/Watering	__	__	__	Itching	__	__	__
Eye Pain or Soreness	__	__	__	Crossed Eyes	__	__	__
Redness	__	__	__	Chronic Infection of Eye or Lid	__	__	__
Blurred Vision	__	__	__	Sties or Chalazion	__	__	__
Flashes/ Floaters in Vision	__	__	__	Tired Eyes	__	__	__

Review of Systems **Height: ______ Weight: ______ Blood Pressure:________**
Do **you** currently, or have you ever had any problems in the following areas:

	No	Yes	?		No	Yes	?
Constitutional				**Musculoskeletal**			
Fever, Weight Loss/Gain	__	__	__	Rheumatoid Arthritis	__	__	__
Cardiovascular				Muscle Pain	__	__	__
Heart Pain	__	__	__	Joint Pain	__	__	__
Heart Disease	__	__	__	**Integumentary (Skin)**	__	__	__
High Blood Pressure	__	__	__	**Neurological**			
Vascular Disease	__	__	__	Headaches	__	__	__
Ears, Nose, Mouth, Throat				Migraines	__	__	__
Allergies/Hay Fever	__	__	__	Seizures	__	__	__
Sinus Congestion	__	__	__	**Psychiatric**	__	__	__
Runny Nose	__	__	__	**Endocrine**	__	__	__
Post-Nasal Drip	__	__	__	Bleeding Problems	__	__	__
Chronic Cough	__	__	__	Thyroid/ Other Glands	__	__	__
Dry throat/Mouth	__	__	__	**Allergic/Immunologic**	__	__	__
Respiratory				**Hematologic/Lymphatic**	__	__	__
Asthma	__	__	__	Anemia	__	__	__
Chronic Bronchitis	__	__	__	Diabetes	__	__	__
Emphysema	__	__	__				
Gastrointestinal							
Diarrhea	__	__	__				
Constipation	__	__	__				
Genitourinary							
Genitals/Kidney/Bladder	__	__	__	**Pregnant**	__	__	__

If yes for Diabetes, Please complete following:
Type I ___ Type II ___
Last BS results? _______ Self Tested __No __Yes
Last A1C Blood work Date ________
Last A1C results ________

If you answered **yes** to any of the above or have a condition not listed, please explain: ____________________________________
____

Do you a work on Computer? __Yes __No If so, how many hours daily? ______ (continued on back side)

Surgical History

List all major injuries, surgeries and/or hospitalizations with dates: ____
____

Past/Present Ocular History Do **you** currently, or have you ever had any problems in the following areas:

	No	Yes	?
Glaucoma	__	__	__
Cataract	__	__	__
ARMD(Macular Degeneration)	__	__	__
Eye Injury	__	__	__
Retinal Disease	__	__	__
Blindness	__	__	__
Strabismus	__	__	__
Amblyopia	__	__	__
Dry Eye	__	__	__
Other Eye Conditions	__	__	__

Family History Please note **any** family history for the following reasons:

Disease/Condition	None	Mother	MGM	MGF	Father	PGM	PGF	Sister	Brother	Uncle	Aunt
Glaucoma	__	__	___	___	____	___	___	___	___	___	___
Cataract	__	__	___	___	____	___	___	___	___	___	___
ARMD (Macular Degeneration)	__	__	___	___	____	___	___	___	___	___	___
Eye Injury	__	__	___	___	____	___	___	___	___	___	___
Crossed Eyes	__	__	___	___	____	___	___	___	___	___	___
Retinal Detachment/Disease	__	__	___	___	____	___	___	___	___	___	___
Blindness	__	__	___	___	____	___	___	___	___	___	___
Strabismus	__	__	___	___	____	___	___	___	___	___	___
Amblyopia	__	__	___	___	____	___	___	___	___	___	___
Diabetes	__	__	___	___	____	___	___	___	___	___	___
Cancer	__	__	___	___	____	___	___	___	___	___	___
Heart Disease	__	__	___	___	____	___	___	___	___	___	___
Kidney Disease	__	__	___	___	____	___	___	___	___	___	___
Thyroid Disease	__	__	___	___	____	___	___	___	___	___	___
Lupus	__	__	___	___	____	___	___	___	___	___	___
High Blood Pressure	__	__	___	___	____	___	___	___	___	___	___
Arthritis	__	__	___	___	____	___	___	___	___	___	___

Other (please list) ____

Social History **This information is kept strictly confidential. However, you may discuss this portion with your doctor if you prefer. ___YES, I would prefer to discuss my Social History information directly with my doctor.**

Do you use Tobacco products? __ No __Yes If yes, type/amount/how long? ____
Do you drink alcohol? __No __Yes If yes, type/amount/how long? ____
Do you use illegal drugs? __No __Yes If yes, type/amount/how long? ____
Have you ever been exposed to or infected with: __ Gonorrhea __ Hepatitis __HIV __Syphilis

Medications and Allergies

List any medications you take(including oral contraceptive, aspirin, over the counter medications and home remedies):____
____
____

Do you have any allergies to medicine? __ No __Yes If yes, explain reaction: ____
____
____

Reviewed by Dr. David B. Gaudreau: __________ Updated:____/____/____