INTERMOUNTAIN EYE CENTERS (Form A)

NAME: _____ **DATE:** _____

MEDICAL HISTORY (List all medical problems, including past surgeries):

_____ _____ _____
_____ _____ _____
_____ _____ _____

FAMILY HISTORY (Parents, grandparents or siblings with macular degeneration, glaucoma, cataract or diabetes):

_____ _____ _____
_____ _____ _____

MEDICAL ALLERGIES (List all allergies to medications and type of reaction):

_____ _____ _____
_____ _____ _____

MEDICATIONS (Include aspirin, vitamins, birth control pills, etc.):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

MEDICAL REVIEW (Check any problems that apply to you):

Constitutional:
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Chronic Fatigue

Ears / Nose / Throat:
- ☐ Loss of Hearing
- ☐ Sinus Problems
- ☐ Swollen Glands
- ☐ Nosebleeds

Allergy / Immunity:
- ☐ Environmental Allergies
- ☐ Lupus

Urinary Tract:
- ☐ Painful Urination
- ☐ Incontinence

Heart / Circulation:
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Sleep With Extra Pillows
- ☐ Extremity Swelling
- ☐ High Blood Pressure

Integumentary:
- ☐ Rashes
- ☐ Lumps in Breast

Endocrine:
- ☐ Diabetes
- ☐ Hormone Therapy
- ☐ Thyroid Disease

Respiratory:
- ☐ Shortness of Breath
- ☐ W h e e z i n g
- ☐ C o u g h i n g

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation

Musculoskeletal:
- ☐ Painful Joints
- ☐ Swollen Joints
- ☐ Osteoporosis
- ☐ Arthritis

Neurological:
- ☐ Numbness / Weakness
- ☐ Loss of Memory
- ☐ Raynaud's

Social History:
Marital Status: ☐ M ☐ S ☐ W ☐ D
Occupation: _____
Do you use tobacco? ☐ YES ☐ NO
How much? _____
Do you use alcohol? ☐ YES ☐ NO
How much? _____

FORM UPDATED ❑ **All unmarked systems WNL** ❑ **Eye History see Form B**