

TALLEY MEDICAL-SURGICAL EYE CARE ASSOCIATES

MEDICAL HISTORY RECORD

www.talleyeyecare.com

Name: _____ Today's Date: ___/___/___ Birthdate: ___/___/___ Age: _____
 Address: _____ E-Mail: _____
 City: _____ State: _____ Zip: _____ Phone: _____ Sex: M F Marital Status: _____
 Employer: _____ Phone: _____ Social Security No.: _____
 Notify in case of emergency: _____ Phone: _____ Relationship: _____
 Family Doctor: _____ Phone: _____ Date of last physical: _____
 Referring Doctor: _____ Phone: _____

List all medications you take: (prescription and over-the-counter) Attach list if necessary.

	(Name)	(Dosage)	(How Often)
(1)	_____	_____	_____
(2)	_____	_____	_____
(3)	_____	_____	_____
(4)	_____	_____	_____
(5)	_____	_____	_____
(6)	_____	_____	_____

Pharmacy: _____ Pharmacy Phone: _____

Do you have allergies to any medications? Yes No

If YES, list medications and reactions: _____

Are you allergic to Latex? Yes No Have you ever had a blood transfusion? Yes No

Is this a Workman's Comp injury? Yes No If YES, explain injury: _____
 Date of injury: _____ Has the accident been reported to your employer? Yes No
 Name and address of employer: _____ Phone: _____

RESPONSIBLE PARTY'S INFORMATION (if minor)

Name: _____ Relationship to patient: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Employer: _____ Work Phone: _____
 Date of Birth: _____ Social Security No.: _____

INSURANCE INFORMATION

Name of Insurance: _____ Name of Cardholder: _____
 ID#: _____ Cardholder's Social Security No.: _____ Cardholder's Birthdate ___/___/___
 Relationship to patient: _____ Cardholder's Employer: _____

REVIEW OF SYSTEMS

Do you presently have any problems in the following areas? If YES, please give an explanation:

	YES	NO	EXPLANATION OF PROBLEM		YES	NO	EXPLANATION OF PROBLEM
EYES				Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sties, chalazion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Are you having any difficulty?:			
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____	Reading small print	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____	Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____	Driving in bright light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	_____	Driving at night	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/light sens.	<input type="checkbox"/>	<input type="checkbox"/>	_____	Reading traffic signs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infection of eye/lid	<input type="checkbox"/>	<input type="checkbox"/>	_____	Writing checks, cards	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Playing golf, tennis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Watching TV/Movies	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you presently have any problems in the following areas?

	YES	NO		YES	NO		YES	NO
GENITOURINARY (Genitals/Kidney/Bladder)			EARS, NOSE, MOUTH, THROAT			CONSTITUTIONAL SYMPTOMS		
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Cervical/Uterine/Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC		
Pregnant now?	<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin and/or Breast)			Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
Skin disease	<input type="checkbox"/>	<input type="checkbox"/>	Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC		
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Breast disease	<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULO-SKELETAL			Heart attacks	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Degenerative arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Irregular/fast heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Blood Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY (Lungs/Breathing)			ALLERGIC/IMMUNOLOGIC		
NEUROLOGICAL			Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Immune problems	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	General allergies	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE		
Stroke/Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL (Stomach/Intestines)			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer-pancreas	<input type="checkbox"/>	<input type="checkbox"/>
			Ulcers/Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
			Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid cancer	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Replacement	<input type="checkbox"/>	<input type="checkbox"/>

PAST HISTORY

List any major illnesses and injuries you have had in the past:

List any significant eye history (i.e.: cataracts, macular degeneration, glaucoma, injuries to eye) you have had:

List any surgeries you have had in the past including approximate date of surgery:

FAMILY HISTORY (M = mother, F = father, S = sibling, GP = grandparent)

DISEASES	YES	NO	RELATIONSHIP TO PATIENT	DISEASES	YES	NO	RELATIONSHIP TO PATIENT
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sjogren's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Do you currently wear glasses? Yes No How long have you had the current pair? _____

Have you ever tried to wear contacts? Yes No

Do you drive? Yes No

Do you smoke? Yes No How many packs a day? _____

Do you drink alcohol? Yes No How many glasses a day? _____

Do you use illegal drugs? Yes No

What is your occupation? _____

For Office Reviewed _____ Date _____ Reviewed _____ Date _____ Reviewed _____ Date _____
 Use Only: Reviewed _____ Date _____ Reviewed _____ Date _____ Reviewed _____ Date _____