ROBERT M. ALLAR, M.D.

PATIENT MEDICAL HISTORY

NAME: ____ DATE: ___________________________

PRESENT PROBLEM: ___________________________________ HOW LONG? ______________________

VISUAL COMPLAINT:	**YES**	**NO**	**EYE HISTORY**:	**YES**	**NO**
DISTORTED / WAVY	____	____	RETINAL DETACH/DISEASE	____	____
BLURRED VISION	____	____	MACULAR DEGEN	____	____
FLOATERS	____	____	LAZY EYE	____	____
FLASHES	____	____	CATARACT	____	____
DARK SPOT	____	____	GLAUCOMA	____	____
NONE	____	____	DIABETIC RETINOPATHY	____	____

EYE SURGERY:	**YES**	**NO**	**FAMILY HISTORY**:	**YES**	**NO**
RETINAL LASERS	____	____	RETINAL DETACH/DISEASE	____	____
RETINAL DETACH	____	____	MACULAR DEGEN	____	____
DIABETIC LASER	____	____	CATARACT	____	____
CATARACTS	____	____	GLAUCOMA	____	____
GLAUCOMA / LASER	____	____	CORNEAL / LASIK	____	____
CORNEAL / LASIK	____	____	DIABETIC RETINOPATHY	____	____

ANY HISTORY OF EYE INJURY: ____

DO YOU TAKE ASPIRIN/ASPIRIN LIKE, COUMADIN, PLAVIX OR ANTI-INFLAMMATORY PRODUCTS? YES____ NO____

IF YES, WHICH ONES? ____

____

ARE YOU TAKING ANY MEDICATIONS? YES____ NO____ **EYE DROPS?** YES____ NO____

PLEASE LIST: ____

____

DO YOU TAKE ANY OVER THE COUNTER VITAMINS, EYE VITAMINS, HERBS, OR SUPPLEMENTS? YES____ NO_____

IF YES, WHICH ONES? ____

ARE YOU ALLERGIC TO ANY MEDICATION? YES____ NO____

IF YES, WHICH ONES? ____

DO YOU OR HAVE YOU EVER SMOKED? YES____ NO____

SMOKING START DATE: __________________ **DATE QUIT:** __________________

DRINK ALCOHOL? YES____ NO_____ **HOW MUCH?** ___________________________

SEE OTHER SIDE

PATIENT MEDICAL HISTORY:

	YES	NO	YEAR DIAGNOSED	FAMILY HX: YES	FAMILY HX: NO
HIGH BLOOD PRESSURE	____	____	____________	____	____
DIABETES: TYPE 1 OR TYPE 2	____	____	____________	____	____
HEART DISEASE / BYPASS	____	____	____________	____	____
STROKE / ATRIAL FIB	____	____	____________	____	____
CHOLESTROL	____	____	____________	____	____
ASTHMA / COPD	____	____	____________	____	____
CANCER-(TYPE):____________	____	____	____________	____	____
ARTHRITIS / RHEUMATOID	____	____	____________	____	____
PREMATURITY	____	____	____________	____	____
THYROID DISEASE	____	____	____________	____	____
OTHER	____	____	____________	____	____

IF YES TO ABOVE, PLEASE EXPLAIN: ____

PRIOR MEDICAL SURGERY/YEAR: ____

REVIEW OF SYSTEMS:

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?	**YES**	**NO**
CHRONIC FEVER, WEIGHT LOSS/GAIN, FATIGUE…	_____	_____
EAR/NOSE/THROAT PROBLEMS (hearing loss, sinus, sore throat, ear ringing)…	_____	_____
ENDOCRINE (diabetic, thyroid) …	_____	_____
CARDIOVASCULAR (chest pain, irregular heartbeat, angina, mitral valve, swelling)…	_____	_____
HEMATOLOGICAL (blood problems, anemia, hepatitis)…	_____	_____
RESPIRATORY PROBLEMS (e.g., shortness of breath, wheezing, coughing)…	_____	_____
GASTROINTESTINAL (heartburn, acid reflux, abdominal pain, diarrhea, vomiting)	_____	_____
URINARY PROBLEMS (pain or discomfort, blood in urine, urgency, incontinence)…	_____	_____
SKIN PROBLEMS (rashes, excessive dryness, eczema)…	_____	_____
MUSCULOSKELETAL (muscle aches, joint pain, swollen joints, stiffness)…	_____	_____
NEUROLOGIC (numbness, weakness, headaches, paralysis, seizures, dizziness, fainting)	_____	_____
PSYCHIATRIC (depression, anxiety, stress, memory loss)…	_____	_____

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN: ______________________________________

SIGNATURE: ________________________________ **DATE:** ____________________

WERE YOU ASSISTED IN ANY WAY WITH THIS FORM?: YES____ NO____

IF YES, NAME OF PERSON WHO ASSISTED YOU: ________________________________