

MICHIGAN EYE INSTITUTE

PATIENT HISTORY (Please Print)

NAME: _____ DATE: _____ AGE: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? (First time patients only)

YELLOW PAGES INSURANCE INTERNET/WEBSITE (mieye.com) DRIVE-BY/WALK-IN
 PATIENT _____ DOCTOR _____
name and relationship to

MEDICAL CONDITIONS - Past or Present (Diabetes, high blood pressure, arthritis, heart attack, etc.)

NONE

SURGERIES, INJURIES, HOSPITALIZATIONS (cataract, laser vision, eye injury, concussions, appendix, etc)

NONE

EYE DISEASES (glaucoma, cataract, "lazy" eye, retinal detachments, etc.)

NONE

MEDICATIONS (dose and times/day) INCLUDE: Eyedrops, Inhalers, Vitamins, OTC (over the counter)

NONE SEE LIST

ALLERGIES INCLUDE: DRUG, food, latex, seasonal, etc.

NONE

PLEASE TURN OVER

REVIEW OF SYSTEMS

Do you **CURRENTLY** have any problems in the following areas? If YES, please provide additional information.

| | YES | NO | DETAILS |
|--|-----|----|---------|
| EYES (poor vision, vision loss, eye pain, double vision, redness, burning, itching, tearing, gritty sensation, dryness, discharge, glare, halos, flashes, floaters, etc.) | | | |
| GENERAL (fever, heat stroke, weight loss, weight gain, unusually tired) | | | |
| EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.) | | | |
| CARDIOVASCULAR (high BP, racing pulse, etc.) | | | |
| RESPIRATORY (congestion, wheezing, short of breath, etc.) | | | |
| GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.) | | | |
| GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.) | | | |
| MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.) | | | |
| SKIN PROBLEMS (acne, warts, growths, rash, etc.) | | | |
| NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.) | | | |
| PSYCHIATRIC (anxiety, depression, insomnia, etc.) | | | |
| ENDOCRINE (diabetes, hypothyroid, etc.) | | | |
| BLOOD/LYMPH (bleeding, high cholesterol, anemia, blood transfusion, etc.) | | | |
| ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.) | | | |
| REPRODUCTIVE (pregnant, nursing, etc.) | | | |

FAMILY HISTORY (Mother, Father, Sibling, Grandparent)

| Do any eye diseases run in your family? (Blindness, Cataract, Glaucoma, Macular Degeneration, Retinal Detachments, etc.) | YES | NO | If YES, please explain |
|---|-----|----|------------------------|
| | | | |
| Do any medical diseases run in your family? (High Blood Pressure, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Diabetes, etc.) | YES | NO | If YES, please explain |
| | | | |

SOCIAL HISTORY

Do you smoke? YES / NO If Yes, how much? _____ How many years? _____

Do you drink alcohol? YES / NO If Yes, how much? _____

Do you use a computer? YES / NO If Yes, hours per day? _____

Hobbies/Sports/Visual Needs: _____

Occupation (current / retired / disabled / student): _____

OFFICE PERSONNEL ONLY

History reviewed: Date: _____ [] No changes [] Additions as noted Tech: _____ Dr.: _____

History reviewed: Date: _____ [] No changes [] Additions as noted Tech: _____ Dr.: _____

History reviewed: Date: _____ [] No changes [] Additions as noted Tech: _____ Dr.: _____

History reviewed: Date: _____ [] No changes [] Additions as noted Tech: _____ Dr.: _____

History reviewed: Date: _____ [] No changes [] Additions as noted Tech: _____ Dr.: _____

History reviewed: Date: _____ [] No changes [] Additions as noted Tech: _____ Dr.: _____

History reviewed: Date: _____ [] No changes [] Additions as noted Tech: _____ Dr.: _____