Medical History

Associated Ophthalmologists of Kansas City
1004 Carondelet Dr., Suite 405, Kansas City, MO 64114

NAME: _____ **DATE _____**
DOB: _____

Eye History:

Please describe the reason for your visit:

_____
_____
_____

Please list any and all previous eye problems and eye surgeries:

_____
_____
_____
_____
_____

Please list current eye medications:

_____
_____

Do you wear glasses? ☐ Yes ☐ No **Age of current/preferred pair**: _____
Do you currently wear contact lenses? ☐ Yes ☐ No

Review of Symptoms: Eyes *(select yes for all that apply and describe as needed)*

Loss of vision	☐ Yes	☐ No	_____
Blurred vision	☐ Yes	☐ No	_____
Double vision	☐ Yes	☐ No	_____
Dry or red eyes	☐ Yes	☐ No	_____
Sandy or gritty eyes	☐ Yes	☐ No	_____
Itching or burning	☐ Yes	☐ No	_____
Foreign body sensation	☐ Yes	☐ No	_____
Excess tearing	☐ Yes	☐ No	_____
Infection of eyelids	☐ Yes	☐ No	_____

Over

Referring Physician_____

Address_____

City/State/Zip_____**Phone**(_____)_____

Primary Care Physician_____

Address_____

City/State/Zip_____**Phone**(_____)_____

Name of other physician specialists that you regularly see:_____

_____

Pharmacy Information

Pharmacy Name _____

Pharmacy Address_____

Pharmacy Phone Number_____

Please list any and all known medication allergies:

_____ *or select* ☐ NONE

If you do not have a list of your current medications, please list below. Also include vitamin supplements and over the counter remedies.

Medication	**Dose**	**Reason for Use**

Do you take aspirin? (select) ☐ **YES** (if yes, _____mg) or ☐ **NO**

Please list any major illnesses and surgeries that you have had in the past:

_____

_____

_____

_____

_____

_____

_____

Occupation /former occupation_____ **Retired**

Smoking now? ☐ **Cigarettes** ☐ **Cigars** ☐ **Pipe** Packs/day**?** _____

Have you ever smoked? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No **If yes, how many glasses per day?** _____

Are you currently using any recreational drugs? ☐ Yes ☐ No _____

Are you currently or could you be pregnant? ☐ Yes ☐ No **Trimester**_____

Family History: (Select) Yes or No			**List their relationship to you:**
Blindness	☐ Yes	☐ No	_____
Cataract	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____
Retinal Detachment	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____

Review of systems. Please check all that apply.

Cardiovascular	***HEENT***	***Musculosketal***	***Respiratory***	***Blood Pressure Control***
☐ Chest pain	☐ Dizziness	☐ Back pain	☐ Cough	☐ Good BP control
☐ Irregular heart beat	☐ Hoarseness	☐ Joint pain	☐ Trouble breathing	☐ Borderline BP control
☐ Shortness of breath	☐ Ringing in ears	☐ Muscle aches	☐ Wheezing	☐ Poor BP control
	☐ Sore throat	☐ Stiffness		☐ Unknown BP control
		☐ Swelling		

Constitutional	***Hematologic***	***Neurological***	***Skin***	***Diabetes Control***
☐ Fatigue	☐ Bleeding	☐ Balance problems	☐ Hair loss	☐ Good DM control
☐ Fever	☐ Bruising	☐ Headache	☐ Rash	☐ Borderline DM control
☐ Night sweats	☐ Tender nodes	☐ Numbness	☐ Skin lesions	☐ Poor DM control
☐ Weakness		☐ Tingling		☐ Unknown DM control
☐ Weight loss				

Genitourinary	***Metabolic***	***Psychiatric***	***Allergy***	***Pregnancy***
☐ Genital discharge	☐ Cold intolerance	☐ Anxiety	☐ Itching	☐ Pregnancy-first trimester
☐ Genital lesions	☐ Excess hunger	☐ Depression	☐ Hives	☐ Pregnancy-second trimester
☐ Painful urination	☐ Excessive thirst	☐ Insomnia	☐ Chronic runny nose	☐ Pregnancy-third trimester
☐ Urgency	☐ Frequent urination	☐ Irritability	☐ Seasonal allergies	☐ Not pregnant
	☐ Heat Intolerance	☐ Nervousness		

None of the above