Rock Hill Eye Center

Patient Medical History Form

Patient Name: _____ **DOB:** _____

Patient Pharmacy: _____ **Primary Physician:** _____

Allergies: _____

Current Medications: _____

Medical History	**Self**	**Family**		**Self**	**Family**
Anxiety			GERD		
Arthritis			Hearing Loss		
Asthma			Hepatitis		
Irregular Heartbeat			Hypertension		
Prostate Enlargement			HIV / AIDS		
COPD			Hypercholesterolemia		
Coronary Artery Disease			Thyroid		
Depression			Radiation Treatment		
Diabetes			Seizures		
End Stage Renal Disease			Stroke		

Cancer: _____

Past Surgeries: _____

Ocular History	**Self**	**Family**		**Self**	**Family**
Allergic Conjunctivitis			Macular ERM		
Blepharitis			Narrow Angles		
Cataract			Ocular Hypertension		
Contact Lenses			Ophthalmic Migraine		
Corneal Dystrophy			Pseudoexfoliation		
Diabetic Retinopathy			Retinal Tear		
Dry Eyes			Strabismus		
Glasses			PVD		
Glaucoma			Vitreous Floaters		
Macular Degeneration			Uveitis		

Past Ocular Surgery	**Right**	**Left**		**Right**	**Left**
Blepharoplasty			Ptosis Repair		
Cataract Surgery			Punctal Plugs		
Corneal Transplant			Retinal Laser		
Intravitreal Injections			Trabeculectomy		
LASIK			Tube Shunt		
Laser			Yag		

Social History	**Yes**	**No**	
Tobacco Use			If yes, how much? _____
Alcohol Use			If yes, how much? _____