CATARACT
CONSULTANTS PA
Laura L. Harris, M.D., F.A.C.S.

PATIENT MEDICAL HISTORY

Name	Nickname	Date

Date of Birth	Age	Phone	Referring Doctor

Past Eye Disease/Injuries:
☐ Yes ☐ No, please describe:

Other surgeries:
☐ Yes ☐ No, please describe:

Eye Medications:
☐ Yes ☐ No, please describe:

Allergies to Food, Medications or Latex:
☐ Yes ☐ No, please describe:

Please answer the following questions about your medical status and history.

Have you ever been treated for any of the following medical conditions? Please check yes or no and circle all that apply. Explain further in the space provided if necessary.

☐ Yes ☐ No Arthritis (Rheumatoid, Osteo-degenerative) _____

☐ Yes ☐ No Blood Disease (Anemia, Leukemia, Clotting problems) _____

☐ Yes ☐ No Ear, Nose, Throat (Hearing Loss, Sinus Disease) _____

☐ Yes ☐ No Diabetes (Type, how controlled when diagnosed) _____

☐ Yes ☐ No Thyroid Disease (Hypo, Hyper, Graves disease_____

☐ Yes ☐ No Lung Disease (Asthma, Emphysema, COPD, Chronic Bronchitis) _____

☐ Yes ☐ No Heart Disease (Heart Attack, Angina, Arrhythmia, Heart Failure, Heart Valve Disease, Bypass Surgery) _____

☐ Yes ☐ No High Blood Pressure _____

☐ Yes ☐ No Gastrointestinal Disease (Ulcers, Esophageal Reflux, Intestinal or Liver Disease) _____

☐ Yes ☐ No Genitourinary Disease (Kidney Disease, Dialysis, Kidney Stones) _____

☐ Yes ☐ No Neurological Problems (Stroke, Mini Strokes, Seizures, Paralysis) _____

☐ Yes ☐ No Skin Disease (Eczema, Psoriasis, Acne, Rosacea) _____

☐ Yes ☐ No Mental Health (Depression, Anxiety, Schizophrenia, Bipolar) _____

☐ Yes ☐ No Cancer (List Type or Location and Date) _____

☐ Yes ☐ No Infectious Disease (TB, Syphilis, Gonorrhea, AIDS, HIV, Hepatitis, MRSA) _____

Other Problems _____

Review of Systems: Do you currently have any of the following problems? Check all that apply.

☐ Yes ☐ No Fever or Weight Loss/Fatigue
☐ Yes ☐ No Ear/Nose/Throat (Hearing Loss/Sinus
☐ Yes ☐ No Cardiovascular (Chest Pain, Irregular Heartbeat)
☐ Yes ☐ No Respiratory (Shortness of Breath, Wheezing)
☐ Yes ☐ No Urinary Problems (Pain or Discomfort, Blood)
☐ Yes ☐ No Skin Problems (Rashes, Excessive Dryness)
☐ Yes ☐ No Musculoskeletal (Muscle Aches, Arthritis)
☐ Yes ☐ No Neurological (Numbness, Weakness, Headaches)
☐ Yes ☐ No Gastrointestinal (Heartburn, Abdominal Pain, Diarrhea)
☐ Yes ☐ No Allergic/Immunologic (Seasonal Allergies, Hay Fever)
☐ Yes ☐ No Psychiatric Problems (Depression, Anxiety)

Eye Disease:
Have you ever had any eye disease? If yes, please explain and include the year diagnosed.

☐ Yes ☐ No Cataract _____
☐ Yes ☐ No Corneal Disease or Transplant _____
☐ Yes ☐ No Diabetic Eye Disease _____
☐ Yes ☐ No Glaucoma _____
☐ Yes ☐ No Lazy Eye (Amblyopia) _____
☐ Yes ☐ No Macular Degeneration _____
☐ Yes ☐ No Muscle Disorder (Crossed Eye) _____
☐ Yes ☐ No Retinal Detachment or Hole _____
☐ Yes ☐ No Injury _____
☐ Yes ☐ No Surgery or Laser _____

Family History of Disease:

Do you have a family history of any of the following disease? If YES, Relative affected. (Ex., mother, father, sister, brother)

☐ Yes ☐ No Diabetes _____
☐ Yes ☐ No Glaucoma _____
☐ Yes ☐ No Retinal Disease _____

Social History:

Smoking Status
Please check the appropriate box

☐ **Current every day smoker**

☐ **Current some day smoker (tobacco)**

☐ **Current some day smoker (cigarette)**

☐ **Former smoker**

☐ **Never smoker**

Alcohol

☐ **Yes** ☐ **No** **Do you consume alcohol? If so, how often** _____

Employment

☐ **Yes** ☐ **No** **Do you work? If so, how many hours?** _____

Patient Signature:	**Date:**
Physician Signature:	**Date:**