SOLOMON EYE PHYSICIANS & SURGEONS
MEDICAL HISTORY FORM

TODAYS DATE:

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:
PRIMARY CARE PHYSICIAN NAME:		
PHYSICIAN LOCATION:	PHYSICIAN PHONE NUMBER:	

SYMPTOMS: CHECK BOX IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

BLURRED OR DISTORTED VISION	TEARING, ITCHING, OR BURNING	EYE PAIN
LIGHT SENSITIVITY	FLASHES OF LIGHT	DROOPING EYELIDS
FOREIGN BODY SENSATION	WEBS OR SPOTS IN YOUR VISION	HEADACHE
REDNESS	DOUBLE VISION	DISCHARGE
LUMPS OR GROWTHS AROUND THE EYES	VISION PROBLEMS WHILE DRIVING, READING, OR WATCHING TV	OTHER:
DRY MOUTH	JOINT PAIN	

FAMILY HISTORY: DO YOU HAVE A FAMILY HISTORY OF (IF YES, WHO?):

CATARACTS:	ARTHRITIS:	DIABETES:
GLAUCOMA:	CANCER:	HEART DISEASE:
MACULAR DEGENERATION:	BLINDNESS:	HYPERTENSION:
MIGRAINES:	THYROID DISEASE:	AUTOIMMUNE DISEASE:

PERSONAL HISTORY: HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING MEDICAL CONDITION?

ALLERGIES (PERTAINING TO EYE)	DIABETES	EYE INJURY	ARTHRITIS	PNEUMONIA
CATARACTS	DIABETIC RETINOPATHY	GLAUCOMA	HYPERTENSION	BLOOD DISORDER
CARDIOVASCULAR DISEASE	DRY EYES	RETINAL DETACHMENT	LUPUS	CANCER
LAZY EYE/CROSS EYE	MACULAR DEGENERATION	ASTHMA	MIGRAINES	ANGINA
THYROID DISEASE	HIGH CHOLESTEROL	OTHER:		

DO YOU TAKE ANY EYE MEDICATIONS (INCLUDING ARTIFICIAL TEARS OR VISINE)? ☐ YES ☐ NO
IF YES, PLEASE LIST/HOW OFTEN: _____

DO YOU TAKE ANY OTHER MEDICATIONS OR HERBAL SUPPLEMENTS? ☐ YES ☐ NO
IF YES, PLEASE LIST: _____

DO YOU HAVE ANY DRUG ALLERGIES? ☐ YES ☐ NO
IF YES, PLEASE LIST: _____

HAVE YOU EVER HAD ANY EYE SURGERIES? ☐ YES ☐ NO
IF YES, PLEASE LIST WITH DATES: _____

IN THE PAST TEN YEARS, HAVE YOU BEEN HOSPITALIZED OR HAD OTHER SURGERY? ☐ YES ☐ NO
IF YES, PLEASE LIST WITH DATES: _____

SOCIAL HISTORY

DO YOU SMOKE?	☐ YES	☐ NO	IF YES, HOW MUCH? _____
DO YOU DRINK ALCOHOL?	☐ YES	☐ NO	IF YES, HOW MUCH? _____
DO YOU EXERCISE REGULARLY?	☐ YES	☐ NO	

REVIEW OF SYMPTOMS: DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?

FATIGUE, UNEXPECTED WEIGHT LOSS/GAIN, CHRONIC FEVER	☐ YES	☐ NO	URINARY PROBLEMS (PAIN, DISCOMFORT, BLOOD IN URINE)	☐ YES	☐ NO
EAR/NOSE/THROAT PROBLEMS (SINUS, SORE THROAT)	☐ YES	☐ NO	MUSCOSKELETAL PROBLEMS (JOINT PAIN, MUSCLE ACHES)	☐ YES	☐ NO
RESPIRATORY PROBLEMS (SHORTNESS OF BREATH, WHEEZING)	☐ YES	☐ NO	SKIN PROBLEMS (EXCESSIVE DRYNESS, RASHES)	☐ YES	☐ NO
HEART PROBLEMS (CHEST PAINS, IRREGULAR HEART BEAT)	☐ YES	☐ NO	NEUROLOGIC PROBLEMS (HEADACHES, PARALYSIS NUMBNESS)	☐ YES	☐ NO
GASTROINTESTINAL PROBLEMS (HEARTBURN, ABDOMINAL PAIN)	☐ YES	☐ NO	PSYCHIATRIC PROBLEMS (DEPRESSION, ANXIETY)	☐ YES	☐ NO

WEIGHT & HEIGHT

WEIGHT: _____ HEIGHT: _____

FOR OFFICE USE ONLY

FIRST REVIEW: _____ DATE: _____
SECOND REVIEW: _____ DATE: _____
THIRD REVIEW: _____ DATE: _____