MILAN EYE CENTER

Patient Name: _____

Eye History:

Y / N Do you wear contacts/glasses/both

Primary Care Physician: _____

Optometrist: _____

Do you currently or have you previously had:

Y / N Cataracts Y / N Keratoconus

Y / N Dry Eyes Y / N Macular degeneration

Y / N Glaucoma Y / N Retinal detachment

Other: _____

List all prior surgeries and date of procedure:

_____ _____

_____ _____

_____ _____

_____ _____

Do you have a family history of any of the following?

Y / N Cataracts Y / N Keratoconus

Y / N Dry Eyes Y / N Macular degeneration

Y / N Glaucoma Y / N Retinal detachment

Over the counter & prescription medications:

_____ _____

_____ _____

_____ _____

List all eye surgeries and date of procedure:

_____ _____

_____ _____

Are you allergic to any medications? YES / No

_____ _____

_____ _____

Past medical history:

Y / N High blood pressure _____

Y / N Heart Problem _____

Y / N Arthritis _____

Y / N Lung Problems _____

Y / N Stroke _____

Y / N Thyroid Problems _____

Y / N Diabetes _____

Y / N High cholesterol _____

Y / N Ulcers _____

Y / N Cancer _____

Y / N Other _____

Family medical history:

Y / N High blood pressure _____

Y / N Heart Problem _____

Y / N Arthritis _____

Y / N Lung Problems _____

Y / N Stroke _____

Y / N Stroke _____

Y / N Diabetes _____

Y / N High cholesterol _____

Y / N Ulcers _____

Y / N Cancer _____

Y / N Other _____

Review of Systems:	**Yes**	**No**	**Details**
Allergic/Immunologic/Blood Lymphatic (Seasonal allergies, Hay fever, Other)			
Cardiovascular (Chest pain, Congestive heart failure, Irregular rhythm, Other)			
Constitutional & Integumentary (Fever, Weight loss, Rash, Skin disease, Other)			
Gastrointestinal (Vomiting, Ulcers, Diarrhea, Bloody stools, Other)			
Genitourinary (Genital ulcers, Discharge, Kidney stones, Blood in urine, Other)			
Head/Neck (Sinus problems, Dry mouth, Post nasal drip, Hearing loss, Runny nose, Other)			
Neurological Psychiatry & Musculoskeletal (Headache, Migraines, Paralysis Fever, Joint ache, Other)			
Respiratory (Cough, Bronchitis, Shortness of breath, Asthma, Emphysema, COPD, Other)			

Social History:

Y / N Smoke currently, ____ packs/day

Y / N Former smoker

Y / N Never smoked

Y / N Drink beer, _____ per day

Y / N Drink wine, _____ per day

Y / N Drink spirits, ____ per day

Would you like a glasses prescription? Yes / No

Patient Signature: _____ Date: _____