OPHTHALMOLOGY
ASSOCIATES OF GREATER ANNAPOLIS

Pediatric-Adult Medical/Surgical History

Last Name: ____________________ First Name: ________________ MI: ___
Date of Birth: ______________ Gender: M / F
For Children: Birth Weight: _____lbs _____oz or _____ grams
Weeks Gestation: _____ If premature, corrected age: _________
Pregnancy/Delivery complications: ______________________________

Past Eye History:	Explanation
Do you wear glasses or contact lenses	Y / N ____________________
Have you ever had laser surgery for your eyes	Y / N ____________________
Have you had eye muscle surgery	Y / N ____________________
Any other surgery on either eye	Y / N ____________________
Eye injuries	Y / N ____________________
Other eye problems	Y / N ____________________

Please list your ocular (eye) medications:

________________ ________________ ________________ ________________
________________ ________________ ________________ ________________

Review of Systems:
Do you now have or in the past had a history of the following? List conditions/explain in the space provided.

Females: are you pregnant or nursing?	Y / N / NA Due Date: ______________
Fever, Chills, Weight loss, fatigue	Y / N ____________________
Skin (rash, eczema, psoriasis, other)	Y / N ____________________
Head (trauma, tumor, aneurysm, infection, other)	Y / N ____________________
Ears, nose, throat (sinuses, hearing, dental, sleep apnea)	Y / N ____________________
Lungs (asthma/reactive airway, COPD, short of breath)	Y / N ____________________
Cardiovascular (high blood pressure, coronary artery disease, heart attack, high cholesterol)	Y / N ____________________
Gastrointestinal (constipation, diarrhea, ulcer, liver disease, inflammatory bowel disease, bleeding)	Y / N ____________________
Kidney, bladder, genital (stones, infections, STD's, tumors)	Y / N ____________________
Musculoskeletal (joint swelling, pain, surgeries)	Y / N ____________________
Neurologic (TIA, stroke, seizures, weakness, numbness)	Y / N ____________________
Blood/Immune System (anemia, swollen lymph nodes, easy bruising, prolonged bleeding)	Y / N ____________________
Endocrine (diabetes, thyroid, pituitary, adrenal)	Y / N ____________________
Psychiatric (depression, anxiety, schizophrenia, obsessive-compulsive, sleep difficulty)	Y / N ____________________

Past Medical and Surgical History: Please list any current or past medical conditions and surgical procedures you have undergone.

____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________
____________________________ ____________________________

Medications: Please list current medications, supplements and dosing if known.

_________________________ _________________________
_________________________ _________________________
_________________________ _________________________
_________________________ _________________________

Allergies: Please list known medication allergies and reactions for each.

Medication	Reaction
_________________________	_________________________
_________________________	_________________________

Family History: Has any relative had any of the following? Please circle Yes or No and state that person's relationship to you.

Amblyopia (poor corrected vision)	Y / N	_________________________
Strabismus (misaligned eyes)	Y / N	_________________________
Cataract	Y / N	_________________________
Glaucoma	Y / N	_________________________
Macular degeneration	Y / N	_________________________
Retinal detachments	Y / N	_________________________
Blindness	Y / N	_________________________
Color vision deficit	Y / N	_________________________
Asthma	Y / N	_________________________
Eczema	Y / N	_________________________
Psoriasis	Y / N	_________________________
Cancer	Y / N	_________________________
Diabetes	Y / N	_________________________
Other	Y / N	_________________________

Social History (adults):

Smoking N / Y Number of packs per day: _____; How Many years: ____When quit: _______
Alcohol N / Y Number of drinks per day/week/month: _________________________
Recreational Drugs N / Y _________________________
Hobbies _________________________
Occupation _________________________ Student N/Y

____________	________	________	________	________	________
Patient/Parent/Guardian Signature	Date	Update	Update	Update	Update

Physician Review		Physician Review	
Initials	Date	Initials	Date
_____	_________	_____	_________
_____	_________	_____	_________
_____	_________	_____	_________
_____	_________	_____	_________