Thomas Eye Group, P.C.

Adult Medical History

Name: _____ Birth Date _____ Today's Date _____

Name of Physician Referring You _____ Physician Phone _____

Date of Last Eye Exam _____

REVIEW OF SYSTEMS

Reviewed: (Initial & Date) _____

Do you have any present problem in the following areas:.
If "yes", please explain

Skin	Yes/No	_____
Eyes	Yes/No	_____
Ears, Nose, Throat, Mouth	Yes/No	_____
Lungs/ Breathing	Yes/No	_____
Heart/ Blood Vessels	Yes/No	_____
Stomach/ Intestines	Yes/No	_____
Genitals/ Kidney/ Bladder	Yes/No	_____
Bones/Joints/Muscles	Yes/No	_____
Neurological (e.g., headaches, palsy)	Yes/No	_____
Blood/ Lymph Nodes/Swelling	Yes/No	_____
Endocrine (e.g., diabetes, thyroid)	Yes/No	_____
Allergic/ Immune System	Yes/No	_____
Psychiatric	Yes/No	_____
Other	Yes/No	_____

HISTORY

List any medication you take: _____

List any surgeries you have had in the past: _____

Do you have any allergies to any medications: Yes/No If yes, list medications: _____

Marital Status (circle one); Single Married Divorced Widowed Other

Present Occupation: _____

Please list any hobbies: _____

Do you smoke? Yes/No If yes, how many packs a day? _____

Do you drink alcohol? Yes/No If yes, how many glasses a day? _____

Do you use other substances? Yes/No If yes, what and how often? _____

FAMILY HISTORY

Any health problems in the family? Circle "yes" or "no". If "yes" indicate relationship to patient:

		Relationship to Patient			Relationship to Patient
Amblyopia (lazy eye)	Yes/No	_____	Strabismus (crossed eye)	Yes/No	_____
Blindness	Yes/No	_____	Diabetes	Yes/No	_____
Cataracts	Yes/No	_____	Heart Disease/Stroke	Yes/No	_____
Glaucoma	Yes/No	_____	High Blood Pressure	Yes/No	_____
Macular Degeneration	Yes/No	_____	Thyroid Disease	Yes/No	_____
Retinal Disease	Yes/No	_____	Cancer	Yes/No	_____
Arthritis	Yes/No	_____	Other	Yes/No	_____