Hattiesburg Eye Clinic
History and Physical Information

Patient Name: _____ **Account #** _____ **Date:** _____

-EYES

Eye disease or injury ..... Yes No
Wear glasses/contact lenses ..... Yes No
Blurred or double vision ..... Yes No
Glaucoma ..... Yes No
Macula Degeneration ..... Yes No

-CONSTITUTIONAL SYMPTOMS

Good general health lately ..... Yes No
Recent weight Change ..... Yes No
Fever ..... Yes No
Fatigue ..... Yes No
Headaches ..... Yes No
Cancer (type) _____ ..... Yes No

-INTEGUMENTARY (skin)

Eczema ..... Yes No
Psoriasis ..... Yes No
Rosacea ..... Yes No
Hives or rash ..... Yes No
Lupus ..... Yes No

-EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing ..... Yes No
Earaches or drainage ..... Yes No
Chronic sinus problem, rhinitis ..... Yes No
Sore throat ..... Yes No
Swollen glands in neck ..... Yes No

-RESPIRATORY

Tuberculosis ..... Yes No
Emphysema ..... Yes No
Chronic or frequent coughs ..... Yes No
COPD ..... Yes No
Shortness of breath ..... Yes No
Asthma of wheezing ..... Yes No

-CARDIOVASCULAR

History of Heart Attack ..... Yes No
History of Bypass Surgery ..... Yes No
Mitral Valve Prolapse ..... Yes No
Arrhythmias ..... Yes No
High Blood Pressure ..... Yes No
Swelling of feet, ankles or hands ..... Yes No
Heart trouble ..... Yes No
Chest pain or angina pectoris ..... Yes No
Palpitations ..... Yes No
Heart murmur ..... Yes No
High cholesterol ..... Yes No
Congestive heart failure ..... Yes No

-GASTROINTESTINAL

Reflux ..... Yes No
Peptic Ulcer ..... Yes No
Loss of appetite ..... Yes No
Nausea or vomiting ..... Yes No

-GENITOURINARY

Frequent urination ..... Yes No
Prostate Trouble ..... Yes No
Kidney Stones ..... Yes No
Kidney Disease ..... Yes No

-MUSCULOSKELETAL

Arthritis .....(type) _____ Yes No
Joint pain ..... Yes No
Weakness of muscles or joints ..... Yes No
Muscle pain or cramps ..... Yes No
Back pain ..... Yes No
Difficulty in walking ..... Yes No
Multiple sclerosis ..... Yes No

-NEUROLOGICAL

Frequent or recent headaches ..... Yes No
Light-headed or dizzy ..... Yes No
Convulsions or seizures ..... Yes No
Paralysis ..... Yes No
Stroke ..... Yes No
Dementia/Alzheimer's ..... Yes No

-ENDOCRINE

Thyroid disease ..... Yes No
Diabetes ..... Yes No
Excessive thirst/urination ..... Yes No
Heat of cold intolerance ..... Yes No

-HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency ..... Yes No
Anemia ..... Yes No
Phlebitis ..... Yes No
Past transfusion ..... Yes No
Enlarged glands ..... Yes No
Sickle Cell Disease/Trait ..... Yes No
Hepatitis.....(type)_____ ..... Yes No
HIV ..... Yes No

-PSYCHIATRIC

Memory loss or confusion ..... Yes No
Nervousness ..... Yes No
Depression ..... Yes No
Insomnia ..... Yes No
Mental Illness ..... Yes No

-ALLERGIC/IMMUNOLOGIC

None Known ..... Yes Type of Reaction
Morphine, Demerol, other ..... Yes No _____
Penicillin or other antibiotic ..... Yes No _____
Novocain or other anesthetics ..... Yes No _____
Aspirin or other pain remedies ..... Yes No _____
Tetanus antitoxin or other serum ... Yes No _____
Mycins ..... Yes No _____
Sulfa/sulphur ..... Yes No _____
Codeine ..... Yes No _____

ANY OTHER DRUG ALLERGIES: _____

_____

CHILDHOOD ILLNESSES: _____

_____

Has anyone in your **FAMILY** had: (If yes, explain)

Yes/No Glaucoma _____

Yes/No Cataracts _____

Yes/No Blindness _____

Yes/No Other Eye Diseases _____

Yes/No Diabetes _____

Yes/No Macular Degeneration _____

Yes/No Hypertension _____

Do **YOU** use? How often?

Tobacco
_____ Currently everyday smoker
_____ Current someday smoker
_____ Former smoker
_____ Never smoked
_____ Smoker currently status unknown
_____ Unknown if ever smoked

Drugs Yes/No _____

Alcohol Yes/No _____

For females: pregnant Yes/No weeks? _____

PATIENT RACE: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, Other race, White

PATIENT ETHNICITY: Hispanic or Latino, Not Hispanic or Latino

Past Anesthetic Complications _____

Have you ever had any **Eye Surgery**? Yes/No *what type? when?* _____

_____

Have you ever had **General Surgeries**? Yes/No *what type? when?* _____

_____

_____

_____

Please list **all Medications, *including dosage and milligrams*** that you are currently taking.
Please include any Eye drops or over-the-counter medications.

MEDICATION NAME / MILLIGRAM	DOSAGE	REASON TAKEN

Patient Signature _____ Patient DOB _____
Parent or Guardian (if minor)

For Office Use Only

Reviewed by: _____ Date _____