Harold I. Rodman, M.D. and Joel M. Engelstein, M.D.

MEDICAL INFORMATION

Date ____/____/____ **DOB** ____/____/____ **Referred by** _____

Name _____ **Family Physician** _____

Reason for today's visit _____

I. Past History (please indicate if none)

1. **Medication Allergies:**

2. **Eye History** (e.g. – Eyeglasses, Contact Lenses, Surgery, Trauma, Laser, Infections, Glaucoma):

3. **Past Medical/Surgical History** (e.g. – High Blood Pressure, High Cholesterol, Diabetes, Thyroid Disorders):

4. **Current Medications:** (List Name and Purpose. Please list all herbal/nutrional supplements and eye drops)

II. Family History (blood relatives):

	NO	YES	Other/Explanation of whom (if YES)
Cataracts	☐	☐	
Glaucoma/High Eye Pressure	☐	☐	
Retinal Detachment	☐	☐	
Macular Degeneration	☐	☐	
Blindness	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Heart Disease	☐	☐	

III. Social History:

☐ Single ☐ Married ☐ Divorced ☐ Widowed Children # _____

Highest level of education: _____ Current (former) occupation: _____

	NO	YES	Other/Explanation (if YES)
Drugs	☐	☐	
Alcohol	☐	☐	

☐ Never smoker ☐ Current Smoker
□ some days
☐ Former smoker □ Light
□ Heavy

Date started: _____ _____ packs per day
Date quit: _____

Review of Systems

Please answer yes or no to all items

	Yes	No
1) Have you experienced unexplained:		
Fever	☐	☐
Weight Loss	☐	☐
Other	☐	☐
2) Eyes		
Blurred vision	☐	☐
Double vision	☐	☐
Pain	☐	☐
Discharge	☐	☐
Other	☐	☐
3) Ears, Nose, Mouth, Throat		
Pain	☐	☐
Mass	☐	☐
Discharge	☐	☐
Hearing loss	☐	☐
Smell	☐	☐
Other	☐	☐
4) Cardiovascular		
Chest pain	☐	☐
Shortness of breath on exertion	☐	☐
Irregular heart beat	☐	☐
Other	☐	☐
5) Respiratory		
Short of breath	☐	☐
Cough	☐	☐
Asthma	☐	☐
Other	☐	☐
6) Gastrointestinal		
Bowel habits/change	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Stomach pain	☐	☐
Ulcers	☐	☐
Other	☐	☐
7) Hemotologic/Lymphatic		
Anemia	☐	☐
Blood disease	☐	☐
Bleeding disorder	☐	☐
Swollen lymph nodes	☐	☐
Other	☐	☐
8) Musculoskeletal		
Weakness	☐	☐
Joint pain	☐	☐
Decreased range of motion	☐	☐
Other	☐	☐
9) Skin/Breast		
Masses	☐	☐
Tumors	☐	☐
Pigmented lesions	☐	☐
Rash	☐	☐
Other	☐	☐
10) Neurologic		
Weakness	☐	☐
Tingling	☐	☐
Numbness	☐	☐
Other	☐	☐