PACIFIC EYE CARE CENTER
1270 Arroyo Way, Walnut Creek, CA 94596
Phone:(925) 945-8188 **Fax:**(925) 945-0360
Website: www.pacificeyecarecenter.org

PATIENT MEDICAL HISTORY

Patient Name:_____

We ask that you update this information yearly. If there are no changes, there is a place to indicate this in each section.

Current Primary Care Physician (your family doctor):_____**Phone:**_____

GENERAL HEALTH HISTORY: Are you currently or have you experienced any of the following? (Circle yes or no)

YES NO	Migraine headache	YES NO	Diabetes
YES NO	Intermittent loss of vision	YES NO	Heart disease
YES NO	Loss of part of vision	YES NO	High blood pressure
YES NO	Double vision	YES NO	Stroke
YES NO	Distorted vision	YES NO	High Cholesterol
YES NO	Unexplained eye pain	YES NO	Anemia
YES NO	Haloes or rainbows around lights	YES NO	Bleeding tendency
YES NO	Glaucoma	YES NO	Breathing trouble
YES NO	Flashes of light	YES NO	Tuberculosis
YES NO	Floaters	YES NO	Urinary trouble
YES NO	Retina trouble	YES NO	Stomach trouble
YES NO	Drooping eyelids	YES NO	Liver trouble
YES NO	Crossed or wandering eyes	YES NO	Epilepsy
YES NO	Lazy eye	YES NO	Cancer
YES NO	Seasonal Allergies	YES NO	Arthritis
YES NO	Serious eye injury:_____	YES NO	Blood transfusion
YES NO	Eye surgery for:_____	YES NO	HIV positive
YES NO	Other eye trouble:_____	YES NO	Recent fever
		YES NO	Recent weight loss

Other conditions you have that we should be aware of:_____

Female patients: Are you pregnant? YES NO

□ ***There have been no changes in my general health history since the last time I completed this form.***

FAMILY HISTORY: Have any of your blood relatives developed the following?

		Relationship:			Relationship:
Blindness	NO YES:	_____	Crossed or wandering eye	NO YES:	_____
Glaucoma	NO YES:	_____	Retinal disease	NO YES:	_____
Cataracts	NO YES:	_____	Other eye trouble:_____	NO YES:	_____
Macular Degeneration	NO YES:	_____	Diabetes	NO YES:	_____
Other inherited disease	NO YES:	_____	*Please list disease:*_____		

□ ***There have been no changes in my family history since the last time I completed this form.***

MEDICATION & DRUG HISTORY:

Have you ever taken or are you taking Flomax (tamsulosin) **for prostate/bladder?** Yes No

Please list all medications you are currently taking, including eye drops, supplements & over the counter medications. If you have a list, we will be happy to make a copy for your convenience. _____

_____

_____

Do you have any allergies to medications? No Yes (please list)**:**_____

_____

Do you take:	**Sedatives**	Never Occas. Freq. Daily	**Tranquilizers**	Never Occas. Freq. Daily
	Sleeping pills, etc	Never Occas. Freq. Daily	**Aspirin Products**	Never Occas. Freq. Daily
	Cortisone	Never Occas. Freq. Daily	**Thyroid medication**	Never Occas. Freq. Daily

Do you use alcohol? Yes (list amount/circle freq) _____drinks per Day/Week/Month No

Do you smoke? Yes (list amount/circle freq) _____ packs per Day/Week/Month No Quit _____ago

□ ***There have been no changes in my medication & drug history since the last time I completed this form.***

Patient Signature:_____**Date:**_____

Doctor has reviewed medical history - Doctor's Initials :_____***Date:***_____