

MAIN OFFICE AND SURGICAL CENTER:  
43309 US Highway 19 N  
Tarpon Springs, FL 34689

LOCAL: 727.938.2020  
TOLL FREE: 800.282.9905

WEB: [StLukesEye.com](http://StLukesEye.com)

## **MEDICAL HISTORY**

**PLEASE PRINT. PLEASE DO NOT MAIL.**

For your personal privacy,  
please close this form once it is completed.

Chart No: \_\_\_\_\_

Date: \_\_\_\_\_

## MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL

Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: M S D W  
Last Name First Name M

Address: \_\_\_\_\_  
Street City State Zip

Phone: (\_\_\_\_) \_\_\_\_\_ Family Doctor: \_\_\_\_\_  
Name

Date of Last Visit: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Tests Performed (please list): \_\_\_\_\_

### PAST OCULAR HISTORY:

Previous History of Eye Treatment or Exams: \_\_\_\_\_

What problems are you having with your eyes? \_\_\_\_\_

### PAST MEDICAL HISTORY: Please check No or Yes for each of the following.

- |  |   |   |  |
|--|---|---|--|
| <b>No Yes</b>  | <b>No Yes</b>   | <b>No Yes</b>   | <b>No Yes</b>  |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> <input type="checkbox"/> Diabetes                | <input type="checkbox"/> <input type="checkbox"/> Anemia               |
| <input type="checkbox"/> <input type="checkbox"/> Pneumonia              | <input type="checkbox"/> <input type="checkbox"/> Angina                    | <input type="checkbox"/> <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Bleeding Problems    |
| <input type="checkbox"/> <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat/Pacer | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> <input type="checkbox"/> Blood Diseases       |
| <input type="checkbox"/> <input type="checkbox"/> Asthma                 | <input type="checkbox"/> <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> <input type="checkbox"/> Hiatal Hernia           | <input type="checkbox"/> <input type="checkbox"/> Radiation/Chemo      |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema              | <input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure  | <input type="checkbox"/> <input type="checkbox"/> Ulcers                  | <input type="checkbox"/> <input type="checkbox"/> Memory Loss          |
| <input type="checkbox"/> <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> <input type="checkbox"/> Stroke                    | <input type="checkbox"/> <input type="checkbox"/> Diverticulosis          | <input type="checkbox"/> <input type="checkbox"/> Alzheimer's          |
| <input type="checkbox"/> <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> <input type="checkbox"/> Claustrophobia            | <input type="checkbox"/> <input type="checkbox"/> Arthritis               | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disorder          | <input type="checkbox"/> <input type="checkbox"/> Phlebitis               | <input type="checkbox"/> <input type="checkbox"/> Seizures             |
|  |   |   | <input type="checkbox"/> <input type="checkbox"/> MRSA                 |
|  |   |   | Other _____  |

### HAVE YOU OR A FAMILY MEMBER BEEN DIAGNOSED WITH THE FOLLOWING?

- |  |  |
|--|--|
| <b>No Yes</b>  | <b>No Yes</b>  |
| <input type="checkbox"/> <input type="checkbox"/> Creutzfeldt-Jakob Disease              | <input type="checkbox"/> <input type="checkbox"/> Fatal Familial Insomnia  |
| <input type="checkbox"/> <input type="checkbox"/> Gerstmann-Straussler-Scheinker Disease | <input type="checkbox"/> <input type="checkbox"/> Have you ever received injections of hormones to increase your height? |

### HOSPITALIZATIONS: Please list the date of any relevant surgeries or hospitalizations.

- |  |   |  |
|--|---|--|
| <b>No Yes</b>  | <b>No Yes</b>   | <b>No Yes</b>  |
| <input type="checkbox"/> <input type="checkbox"/> Eye Surgery _____  | <input type="checkbox"/> <input type="checkbox"/> Stomach/Abdomen _____ | <input type="checkbox"/> <input type="checkbox"/> Cancer _____       |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid/Neck _____ | <input type="checkbox"/> <input type="checkbox"/> Gallbladder _____     | <input type="checkbox"/> <input type="checkbox"/> Prostate _____     |
| <input type="checkbox"/> <input type="checkbox"/> Heart _____        | <input type="checkbox"/> <input type="checkbox"/> Appendectomy _____    | <input type="checkbox"/> <input type="checkbox"/> Hysterectomy _____ |
| <input type="checkbox"/> <input type="checkbox"/> Lungs _____        | <input type="checkbox"/> <input type="checkbox"/> Hernia _____          | Other _____  |
| <input type="checkbox"/> <input type="checkbox"/> Mastectomy _____   | <input type="checkbox"/> <input type="checkbox"/> Back _____            | Other _____  |

Chart No: \_\_\_\_\_

Date: \_\_\_\_\_

Patient: \_\_\_\_\_  
Last Name First Name M

**PRESENT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS:**

Please list name, dose and frequency. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES TO MEDICATIONS:**     No Known Allergies    Latex Sensitivity:     No     Yes

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY:**

	Living?		Medical Problems or Cause of Death
	No	Yes	
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister/Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list any history of eye disease or eye surgery in your family: \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:** Do (Did) you:

No	Yes	Former			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smoke	How much per day? _____	For how many years? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink Alcohol	How much per day? _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational Drug Use	How much per day? _____	

**REVIEW OF SYSTEMS:** Do you have these now? If yes, circle condition and explain.

- No Yes
- Skin:** Psoriasis/Rash/Shingles \_\_\_\_\_
  - Head:** Headache/Migraines/Temporal Arteritis \_\_\_\_\_
  - Eyes:** Cataract/Glaucoma/Retina \_\_\_\_\_
  - Ears:** Hearing Loss/Aids \_\_\_\_\_
  - Nose/Mouth/Throat:** Dentures/Sinus \_\_\_\_\_
  - Neck:** Restriction of Movement/Difficulty swallowing \_\_\_\_\_
  - Pulmonary:** Cough/Shortness of Breath/Wheeze \_\_\_\_\_
  - CV:** Chest Pain/Palpitations \_\_\_\_\_
  - GI:** Ulcers/Pain \_\_\_\_\_
  - MS:** Leg Cramps/Swelling \_\_\_\_\_
  - Neuro:** Tremor/Speech Problems \_\_\_\_\_
  - Psych:** Anxiety/Depression/Insomnia/Panic Attacks \_\_\_\_\_

