Drs. Campbell Cunningham Taylor & Haun

EyeCare Optical
A Division of Drs. Campbell, Cunningham, Taylor & Haun

Patient Name: **DOB:** **Date:**

Review of Systems
Do you have a history with any of the following? Please check Yes or No:

Constitutional - Weight Loss/Gain, Fever	☐ YES	☐ NO
Ear, Nose, Throat, Mouth - Sinus	☐ YES	☐ NO
Cardiovascular - Heart, High Blood Pressure	☐ YES	☐ NO
Respiratory - Lung, Breathing, Asthma, TB	☐ YES	☐ NO
Gastrointestinal - Stomach, Intestines, Hepatitis	☐ YES	☐ NO
Genitourinary - Genital, Kidneys, Bladder	☐ YES	☐ NO
Integumentary - Skin	☐ YES	☐ NO
Musculoskeletal - Arthritis, Muscle, Joints	☐ YES	☐ NO
Neurological/Psychiatric - Depression, Nerves, MS	☐ YES	☐ NO
Endocrine - Diabetes, Thyroid	☐ YES	☐ NO
Hematologic/Lymphatic - Anemia, Bleeding Tendency	☐ YES	☐ NO
Allergic/Immunologic - Lupus, Sjogrens, HIV	☐ YES	☐ NO
Hematologic/Lymphatic - Anemia, Bleeding Tendency	☐ YES	☐ NO
Other – Cancer, Stroke, Etc.	☐ YES	☐ NO

Please list the medications and dosage you are currently taking including eye medication:

_____ _____ _____

_____ _____ _____

Please list allergies to medication:

Ocular History
Have you ever been diagnosed with any of the following?

Cataracts	☐ Yes ☐ No	Cornea Disease	☐ Yes ☐ No	Retina/Macular Disease	☐ Yes ☐ No
Crossed Eyes	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Other Eye Disorders	☐ Yes ☐ No

Eye Surgeries:

Cataract: ☐ Yes Surgery Date: ☐ Right Eye ☐ Left Eye ☐ Both Eyes ☐ No Surgery
Retina: ☐ Yes Surgery Date: ☐ Right Eye ☐ Left Eye ☐ Both Eyes ☐ No Surgery

Eye Injuries:

Family and Social History
Do any of your family members have a history of the following?

Glaucoma	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Retinal Detachment:	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Retinal/Macular Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Heart Problems:	☐ Yes ☐ No	Other:	

Occupation:

Do you drink? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No
Are you Pregnant? ☐ Yes ☐ No Are you Nursing? ☐ Yes ☐ No

Medical History

Drs. Campbell Cunningham
Taylor & Haun

Your Information

1. Patient Name _____ Chart# _____ Today's Date: _____

Medical History

2. Primary care doctor: _____ Tel: _____
3. Do you now, or have you ever had:

						Diagnosis date:
a. Diabetes				Yes ☐	No ☐	
Treatment:	diet control ☐	oral agents ☐	insulin ☐	other ☐		
Medical complication:	kidney ☐	vascular ☐	eye ☐	other ☐		
b. Heart attack				Yes ☐	No ☐	
Angina or chest pain				Yes ☐	No ☐	
Heart failure				Yes ☐	No ☐	
Irregular or rapid heart beat				Yes ☐	No ☐	
Cardiac pacemaker inserted				Yes ☐	No ☐	
c. High blood pressure				Yes ☐	No ☐	
d. Stroke or TIA				Yes ☐	No ☐	
e. Anemia				Yes ☐	No ☐	
f. Asthma				Yes ☐	No ☐	
Emphysema and/or bronchitis				Yes ☐	No ☐	
Pneumonia				Yes ☐	No ☐	
Tuberculosis				Yes ☐	No ☐	
g. Liver disease or jaundice				Yes ☐	No ☐	
h. Stomach or duodenal ulcer				Yes ☐	No ☐	
i. Kidney stones / other kidney disease				Yes ☐	No ☐	
j. Arthritis: rheumatoid ☐ osteo ☐				Yes ☐	No ☐	
k. Cancer or tumor				Yes ☐	No ☐	
Type: _____						
Treatment: _____						
l. Thyroid disease: underactive ☐ overactive ☐				Yes ☐	No ☐	
Treatment: _____						
m. Migraine				Yes ☐	No ☐	
n. Blood clot in legs				Yes ☐	No ☐	
o. Bleeding disorders				Yes ☐	No ☐	
p. Transfusions of blood or plasma				Yes ☐	No ☐	
q. HIV positive, AIDS				Yes ☐	No ☐	
r. Other medical problems				Yes ☐	No ☐	
Please describe: _____						

4. Are you allergic to any medications or foods? Yes ☐ No ☐ _____
   If yes, please describe substance(s), with type of reaction: _____

Medications

5. Please list all medications you are using at present in the spaces provided below: _____

Eye medication(s):

Name	Dose	Frequency	Eye

All other medication(s):

Name	Dose	Frequency