Cornea & Cataract Consultants of Nashville Patient Medical History Date: _____

Name: Mrs. /Ms. /Miss/Mr. _____ DOB: _____

Pharmacy/Location (Address with Proper City): _____

Referring Physician: _____

YOUR Eye History Yes No **(IF YES PLEASE INDICATE WHICH EYE AND THE APPROXIMATE DATE)**

Cataract Surgery				Do You Wear:
Laser Eye Surgery				☐ Glasses
Other Eye Surgery				☐ Contacts
Eye Disease/Injury				
Other Eye Problems				

Please check or write in YOUR medical history below

Cardiovascular	Genitourinary	Immunologic	Muscular skeletal	MISC.
☐ Heart Disease ☐ High Blood Pressure ☐ Other ☐ None	☐ Kidney Disease ☐ Renal Failure ☐ Chronic UTI ☐ Other ☐ None	☐ Shingles ☐ Hay fever ☐ Lupus ☐ Sarcoidosis ☐ HIV ☐ Other ☐ None	☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Carpel Tunnel ☐ Osteoporosis ☐ Other ☐ None	
Dermatologic	**HEENT**	**Infectious Disease**	**Neoplastic**	**Pulmonary**
☐ Skin Condition ☐ Acne Rosacea ☐ Stevens-Johnson Syndrome ☐ Other ☐ None	☐ Sinus Problems ☐ Hearing Loss ☐ Mouth Sores ☐ Other ☐ None	☐ Hepatitis A B C ☐ Herpes ☐ TB ☐ HIV ☐ MRSA ☐ Other ☐ None	☐ Cancer ☐ Breast Cancer ☐ Ovarian Cancer ☐ Colon Cancer ☐ Lung Cancer ☐ Brain Tumor ☐ Prostate Cancer ☐ Skin Cancer ☐ Other ☐ None	☐ Lung Disease ☐ Asthma ☐ Emphysema ☐ Sleep Apnea ☐ Bronchitis ☐ COPD ☐ Other ☐ None
Gastrointestinal	**Hematologic**	**Metabolic/endocrine**	**Neuro/psychiatric**	**Women's Health**
☐ Stomach Problems ☐ Liver Disease ☐ GERD ☐ Gastric Ulcer ☐ Diverticulitis ☐ Other ☐ None	☐ Bleeding Disorder ☐ Anemia ☐ Coumadin Therapy ☐ Other ☐ None	☐ Non-insulin dependant Diabetes ☐ Insulin dependant Diabetes ☐ Thyroid Disease ☐ Graves' Disease ☐ Pituitary Tumor ☐ Other ☐ None	☐ Stroke R L side ☐ Migraine headaches ☐ TIAs ☐ Depression ☐ Anxiety syndrome ☐ Post Traumatic Stress Disorder ☐ Parkinson's Disease ☐ Other ☐ None	☐ Pregnancy ☐ Child Birth **Other** ☐ Bell's Palsy ☐ None

Date of your most recent physical examination: _____

Primary Care Physician: _____ Office Phone Number: _____

Office Address: _____ City: _____ State: _____ Zip: _____

List any other major ILLNESSES, HOSPITALIZATIONS, and SURGERIES. (With the year, if possible)

Please list all MEDICATIONS that you are using. Add dosage and frequency. If none, check here ☐

EYE Medications:

OTHER Medications:

Are you **ALLERGIC** to any medications? Yes No If **YES**, please list.

Have any FAMILY members or RELATIVES had any of the following?

	Yes	No	(Relationship to you)
Cataract			
Glaucoma			
Cornea Problems			
Retina Detachment			
Blindness			
OTHER			
Diabetes			
Heart Disease			
Cancer			
OTHER			

Your Occupation: Marital Status: ☐ Married ☐ Single ☐ Widow(er)

	Yes	No	
Do you smoke?			
Do you drink alcohol?			
Use/abuse Drugs?			

FOR OFFICE USE ONLY

☐ I have reviewed this medical history.
☐ I have made additions to this medical history as noted above or in exam form.

_____M.D. Date:_____ Tech: _____