Viet H. Ho, M.D., A Professional Corporation

PATIENT MEDICAL HISTORY

PATIENT NAME:_____ Date: _____

DOB:_____/_____/_____

DRUG ALLERGIES? YES ☐ NO ☐ Please list:_____

MEDICATIONS currently taking: Blood thinners (plavix, coumadin, aspirin/NSAIDS) _____

_____

_____

PERSONAL MEDICAL HISTORY: Have you ever had the following diseases?

YES	NO		YES	NO	
☐	☐	Cataracts	☐	☐	Diabetes
☐	☐	Glaucoma	☐	☐	High blood pressure
☐	☐	Floaters	☐	☐	Blood disorder
☐	☐	Retinal detachment	☐	☐	Heart disease
☐	☐	Macular degeneration	☐	☐	Congestive heart failure
☐	☐	Dry/watery eyes	☐	☐	Cancer
☐	☐	Lazy eye	☐	☐	Cholesterol
☐	☐	Eye injury/surgeries	☐	☐	Migraines
☐	☐	Eye infection	☐	☐	Rosacea
☐	☐	Arthritis	☐	☐	Sleep apnea
☐	☐	Asthma	☐	☐	Stroke
			☐	☐	Thyroid problems

Other illnesses/injuries/hospitalizations:_____

List all SURGICAL procedures/dates:

_____

_____

FAMILY HISTORY: Has anyone in your family had:

☐ Cataracts	☐ Macular degeneration	☐ Heart Disease
☐ Glaucoma	☐ Diabetes	☐ Cancer
☐ Retinal detachment	☐ High Blood Pressure	☐ Thyroid

SOCIAL HISTORY: Current Occupation:_____ Marital Status:_____

Do you smoke? YES ☐ NO ☐ Packs/Day?_____

Do you drink alcohol? YES ☐ NO ☐ How often?_____

Do you use recreational drugs? YES ☐ NO ☐ How often?_____

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REVIEW OF SYSTEMS

PATIENT NAME: _____

DOB: ____/____/_____

Do you currently have any problems in the following areas?

Yes	*No*	***Constitutional symptoms***
□	□	Fever/malaise
□	□	Weight loss/poor appetite

Yes	*No*	***Eyes***
□	□	Blurred vision
□	□	Double vision
□	□	Floating objects in vision
□	□	Flashing lights
□	□	Redness
□	□	Itching/burning
□	□	Excess tearing
□	□	Glare/light sensitivity
□	□	Eye pain/soreness
□	□	Visual difficulties when driving

Yes	*No*	***Ears, Nose, Mouth, Throat***
□	□	Recent viral infection
□	□	Sore throat
□	□	Loss of hearing/deafness

Yes	*No*	***Cardiovascular***
□	□	Chest pain
□	□	Irregular heart beat

Yes	*No*	***Respiratory***
□	□	Chronic bronchitis/emphysema
□	□	Shortness of breath

Yes	*No*	***Gastrointestinal***
□	□	Stomach ache/pain
□	□	Diarrhea

Yes	*No*	***Genitourinary***
□	□	Burning with urination
□	□	Kidney infection/bleeding

Yes	*No*	***Musculoskeletal***
□	□	Muscle aches/cramps
□	□	Back/neck pain or stiffness
□	□	Joint pains or stiffness

Yes	*No*	***Integumentary/Skin***
□	□	Rashes/dryness
□	□	Facial acne

Yes	*No*	***Neurological***
□	□	Severe headaches
□	□	Seizures

Yes	*No*	***Psychiatric***
□	□	Depression
□	□	Mental health conditions

Yes	*No*	***Endocrine***
□	□	Thyroid problems

Yes	*No*	***Hematologic/lymphatic***
□	□	Anemia
□	□	Easy bruising

Yes	*No*	***Allergic/immunologic***
□	□	Hay fever/seasonal allergy
□	□	Skin or respiratory

Performed/Reviewed/Updated by _____M.D. Date: ____/____/_____