PHYSICIAN: MARK J. BOERNER, M.D. PATIENT MEDICAL HISTORY RECORD FORM B

PATIENT NAME:_____ DATE:_____

MEDICAL STATUS AND HISTORY

1. HAVE YOU EVER BEEN TREATED FOR ANY MEDICAL CONDITIONS (E.G., DIABETES, HIGH BLOOD PRESSURE, ARTHRITIS, ETC.)? YES NO

YES, PLEASE EXPLAIN:_____

_____

2. HAVE YOU EVER BEEN DIAGNOSED WITH **SLEEP APNEA** OR DO YOU USE A **C-PAP MACHINE**? YES NO

YES, PLEASE EXPLAIN:_____

3. HAVE YOU HAD PREVIOUS SURGERIES YES NO YES, PLEASE LIST

_____

4. DO YOU TAKE ANY MEDICATIONS? YES NO

YES, PLEASE LIST_____

_____

5. DO YOU TAKE ANY EYE MEDICATIONS? YES NO

YES, PLEASE LIST_____

6. DO YOU HAVE ANY DRUG ALLERGIES YES NO

YES, PLEASE LIST _____

7. HAVE YOU HAD ANY EYE INJURIES OR OPERATIONS? YES NO

YES, PLEASE LIST _____

_____

8. DO YOU HAVE A SENSITIVITY OR ALLERGY TO LATEX? YES NO

9. **DO YOU HAVE ANY FOOD ALLERGIES?** YES NO

PLEASE LIST _____

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?

CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE Y N

EXPLAIN _____

EAR/NOSE/THROAT PROBLEMS (E.G., HEARING LOSS, SINUS PROBLEMS, SORE THROAT Y N

EXPLAIN_____

HEART PROBLEMS (E.G., CHEST PAIN, IRREGULAR HEART BEAT) Y N

EXPLAIN_____

RESPIRATORY PROBLEMS (EG., SHORTNESS OF BREATH, WHEEZING, COUGHING) Y N

EXPLAIN_____

REVIEW OF SYSTEMS (CONTINUED)

GASTROINTESTINAL PROBLEMS (EG., HEARTBURN, ABDOMINAL PAIN, DIARRHEA) Y N

EXPLAIN_______

URINAL PROBLEMS (E.G., PAIN OR DISCOMFORT, BLOOD IN URINE) Y N

EXPLAIN_____

SKIN PROBLEMS (EG., RASHES, EXCESSIVE DRYNESS) Y N

EXPLAIN_____

MUSCULOSKELETAL PROBLEMS (E.G., MUSCLE ACHES, JOINT PAIN, SWOLLEN JOINTS Y N

EXPLAIN_____

NEUROLOGIC PROBLEMS (EG., NUMBNESS, WEAKNESS, HEADACHES, PARALYSIS) Y N

EXPLAIN_____

PSYCHIATRIC PROBLEMS (E.G., DEPRESSION, ANXIETY Y N

EXPLAIN_____

DO YOU SMOKE? Y N HOW MUCH? _____ DO YOU DRINK? Y N HOW MUCH? _____

FAMILY HISTORY

DO ANY MEDICAL OR EYE DISEASES RUN IN YOUR FAMILY (E.G,) DIABETES, HIGH BLOOD PRESSURE, CANCER, GLAUCOMA, MACULAR DEGENERATION)?

_____

_____

REASON FOR TODAYS EXAM

_____

_____

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Signed (Patient or parent if minor) _____ Date _____

Relationship (Patient or parent if minor) _____