KOBY KARP DOCTORS EYE INSTITUTE

4004 DUPONT CIRCLE ● LOUISVILLE, KY 40207

PATIENT MEDICAL HISTORY

Name ______________________________ **Date** ______________

Please answer all of the following questions. This information is necessary for your doctor to evaluate your condition.

1. Have you ever been treated for any medical condition (diabetes, high blood pressure, arthritis, etc.)?
Yes ______ No ______ If YES, please explain:______________________________

2. Have you ever had any eye disease or eye surgery (glaucoma, cataract, lazy eye)?
Yes ______ No ______ If YES, please explain:______________________________

3. Have you ever had any type of surgery?
Yes ______ No ______ If YES, please provide date and reason______________________________

4. Have you ever been hospitalized?
Yes ______ No ______ If YES, please provide date and reason______________________________

5. Do you take any medications?
Yes ______ No ______ If YES, please list name and reason______________________________

6. Do you take any eye medications?
Yes ______ No ______ If YES, please list______________________________

7. Do you have any food or drug allergies?
Yes ______ No ______ If YES, please list______________________________

REVIEW OF SYSTEMS

Do you currently have any of the following problems:	Yes	No	Explain
Chronic fever, unexpected weight loss/gain, fatigue			
Ear/nose/throat problems (hearing loss, sinus problems, etc)			
Heart Problems (chest pain, irregular heartbeat, etc)			
Respiratory problems (Shortness of breath, wheezing, etc)			
Gastrointestinal problems (heartburn, diarrhea, stomach pain)			
Urinary problems (blood in urine, pain or discomfort, etc)			
Skin problems (rashes, excessive dryness, etc)			
Musculoskeletal problems (muscle aches, joint pain, etc)			
Neurologic problems (numbness, weakness, headaches, etc)			
Psychiatric problems (depression, anxiety, etc)			

Family and Social History:
Do any medical or eye diseases run in your family (diabetes, glaucoma, hypertension, cancer, etc)
Yes ______ No ______ If YES, please explain______________________________
Do you smoke?_________
Comments:______________________________

Doctor Signature______________________________ **Date** ______________