ADELSON
EYE & LASER CENTER

Dr. Howard Adelson, D.O., FAOCO
Dr. Todd Adelson, D.O

PATIENT MEDICAL HISTORY

Patient Name ______________________________ Date ______________

PROBLEM	YES/ NO	EXPLANATION
Fever	❑ Yes ❑ No	____________
Weight Loss	❑ Yes ❑ No	____________
EYE CONCERNS		
Blurred Vision	❑ Yes ❑ No	____________
Double Vision	❑ Yes ❑ No	____________
Pain	❑ Yes ❑ No	____________
Discharge	❑ Yes ❑ No	____________
Other	❑ Yes ❑ No	____________
EARS/NOSE/MOUTH/THROAT		
Pain	❑ Yes ❑ No	____________
Mass	❑ Yes ❑ No	____________
Discharge	❑ Yes ❑ No	____________
Hearing Loss	❑ Yes ❑ No	____________
Loss of smell	❑ Yes ❑ No	____________
Other	❑ Yes ❑ No	____________
CARDIOVASCULAR		
Chest Pain	❑ Yes ❑ No	____________
Coronary Artery Disease	❑ Yes ❑ No	____________
High Blood Pressure	❑ Yes ❑ No	____________
Congestive Heart Failure	❑ Yes ❑ No	____________
Irregular Heartbeat	❑ Yes ❑ No	____________
Stroke	❑ Yes ❑ No	____________
Pacemaker	❑ Yes ❑ No	____________
RESPIRATORY		
Shortness of Breath	❑ Yes ❑ No	____________
Chronic Cough/Wheezing	❑ Yes ❑ No	____________
Asthma	❑ Yes ❑ No	____________
Emphysema	❑ Yes ❑ No	____________
Home Use of Oxygen	❑ Yes ❑ No	____________
ENDOCRINE		
Diabetes	❑ Yes ❑ No	____________
Thyroid Problems	❑ Yes ❑ No	____________

Do you smoke?
❑ Yes ❑ No
# of packs/day _______
# of years _________

Do you use alcohol?
❑ None ❑ Socially
❑ 2-3 times/week
❑ with dinner

Do you exercise?
❑ None ❑ occassionally
❑ weekly ❑ daily

Do you drive?
❑ Yes ❑ No

Occupation:

____

Social History:
❑ single
❑ married
❑ divorced
❑ widowed

PATIENT MEDICAL HISTORY (page 2)

GASTROINTESTINAL

Condition	Yes	No	Notes
Bowel Changes	❑ Yes	❑ No	________
Crohns Disease	❑ Yes	❑ No	________
Hiatal Hernia	❑ Yes	❑ No	________
Stomach Pain	❑ Yes	❑ No	________
Ulcers	❑ Yes	❑ No	________
Other	❑ Yes	❑ No	________

HEMATOLOGIC/LYMPHATIC

Condition	Yes	No	Notes
Anemia	❑ Yes	❑ No	________
Hepatitis	❑ Yes	❑ No	________
Hemophilia	❑ Yes	❑ No	________
HIV +	❑ Yes	❑ No	________
Rheumatic Fever	❑ Yes	❑ No	________
Tuberculosis	❑ Yes	❑ No	________

MUSCULOSKELETAL

Condition	Yes	No	Notes
Weakness/Numbness	❑ Yes	❑ No	________
Joint Pain/Muscle Pain	❑ Yes	❑ No	________
Artificial Joint	❑ Yes	❑ No	________
Arthritis	❑ Yes	❑ No	________

SKIN/BREAST

Condition	Yes	No	Notes
Masses	❑ Yes	❑ No	________
Tumors	❑ Yes	❑ No	________
Rash	❑ Yes	❑ No	________
Bruising	❑ Yes	❑ No	________
Herpes	❑ Yes	❑ No	________

NEUROLOGIC

Condition	Yes	No	Notes
Seizures	❑ Yes	❑ No	________
Epilepsy	❑ Yes	❑ No	________
Parkinson's Disease	❑ Yes	❑ No	________
Dizzy Spells	❑ Yes	❑ No	________
Sever Headaches/Migraines	❑ Yes	❑ No	________

RENAL

Condition	Yes	No	Notes
Kidney Disease	❑ Yes	❑ No	________
Dialysis	❑ Yes	❑ No	________
Transplant	❑ Yes	❑ No	________
Frequent Urinary Tract Infection	❑ Yes	❑ No	________

CANCER

Condition	Yes	No	Notes
Treatment	❑ Yes	❑ No	________
Chemotherapy	❑ Yes	❑ No	________
Radiation	❑ Yes	❑ No	________
Surgery	❑ Yes	❑ No	________

FOR OFFICE USE ONLY

PLEASE DO NOT WRITE BELOW THIS LINE

ROS & Social History Updates

Year	Initials
______	______
______	______
______	______
______	______

FOR OFFICE USE ONLY

Reviewed by:

PHYSICIAN SIGNATURE:

____

Date ________