ADELSON
EYE & LASER CENTER

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

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

Bowel Changes	❑ Yes	❑ No	_____
Crohns Disease	❑ Yes	❑ No	_____
Hiatal Hernia	❑ Yes	❑ No	_____
Stomach Pain	❑ Yes	❑ No	_____
Ulcers	❑ Yes	❑ No	_____
Other	❑ Yes	❑ No	_____

HEMATOLOGIC/LYMPHATIC

Anemia	❑ Yes	❑ No	_____
Hepatitis	❑ Yes	❑ No	_____
Hemophilia	❑ Yes	❑ No	_____
HIV +	❑ Yes	❑ No	_____
Rheumatic Fever	❑ Yes	❑ No	_____
Tuberculosis	❑ Yes	❑ No	_____

MUSCULOSKELETAL

Weakness/Numbness	❑ Yes	❑ No	_____
Joint Pain/Muscle Pain	❑ Yes	❑ No	_____
Artificial Joint	❑ Yes	❑ No	_____
Arthritis	❑ Yes	❑ No	_____

SKIN/BREAST

Masses	❑ Yes	❑ No	_____
Tumors	❑ Yes	❑ No	_____
Rash	❑ Yes	❑ No	_____
Bruising	❑ Yes	❑ No	_____
Herpes	❑ Yes	❑ No	_____

NEUROLOGIC

Seizures	❑ Yes	❑ No	_____
Epilepsy	❑ Yes	❑ No	_____
Parkinson's Disease	❑ Yes	❑ No	_____
Dizzy Spells	❑ Yes	❑ No	_____
Sever Headaches/Migraines	❑ Yes	❑ No	_____

RENAL

Kidney Disease	❑ Yes	❑ No	_____
Dialysis	❑ Yes	❑ No	_____
Transplant	❑ Yes	❑ No	_____
Frequent Urinary Tract Infection	❑ Yes	❑ No	_____

CANCER

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 _____