



EDWARD J. MALIK, O.D., CHTD.

Medical History

Do you have any allergies to medications? no yes If yes, explain:

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had:

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injury.

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses?

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses?

Circle type of contact lenses: rigid, soft, extended wear, other. Are they comfortable? no yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition

Blindness	<input type="radio"/> no	<input type="radio"/> yes	Diabetes	<input type="radio"/> no	<input type="radio"/> yes
Cataract	<input type="radio"/> no	<input type="radio"/> yes	Heart Disease	<input type="radio"/> no	<input type="radio"/> yes
Crossed Eyes	<input type="radio"/> no	<input type="radio"/> yes	High Blood Pressure	<input type="radio"/> no	<input type="radio"/> yes
Glaucoma	<input type="radio"/> no	<input type="radio"/> yes	Kidney Disease	<input type="radio"/> no	<input type="radio"/> yes
Macular Degeneration	<input type="radio"/> no	<input type="radio"/> yes	Lupus	<input type="radio"/> no	<input type="radio"/> yes
Retinal Detachment/Disease	<input type="radio"/> no	<input type="radio"/> yes	Thyroid Disease	<input type="radio"/> no	<input type="radio"/> yes
Arthritis	<input type="radio"/> no	<input type="radio"/> yes			
Cancer	<input type="radio"/> no	<input type="radio"/> yes	Other _____		

Social History

This information is kept strictly confidential. However, you may discuss this portion with the doctor, if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (check oval)

Do you drive? no yes If yes, do you have difficulty when driving? no yes If yes, please describe:

Do you use tobacco products? no yes If yes, type/amount/how long:

Do you drink alcohol? no yes If yes, type/amount/how long:

Circle any condition you ever been exposed to or infected with: Gonorrhea, Hepatitis, HIV, Syphilis

Review of Systems

Do you currently, or have you ever, had any problems in the following areas:

Constitutional

Fever, Weight Loss/Gain no yes

Integumentary (Skin) no yes

Neurological

Headaches no yes

Migraines no yes

Seizures no yes

Eyes

Loss of Vision no yes

Blurred Vision no yes

Distorted Vision/Halos no yes

Loss of Side Vision no yes

Double Vision no yes

Dryness no yes

Mucous Discharge no yes

Redness no yes

Sandy or Gritty Feeling no yes

Itching no yes

Burning no yes

Foreign Body Sensation no yes

Excess Tearing/Watering no yes

Glare/Light Sensitivity no yes

Eye Pain or Soreness no yes

Chronic Infection of Eye or Lid no yes

Sties or Chalazion no yes

Flashes/Floaters in Vision no yes

Tired Eyes no yes

Endocrine

Thyroid/Other Glands no yes

Allergic/Immunologic no yes

Ears, Nose, Mouth, Throat

Allergies/Hay Fever no yes

Sinus Congestion no yes

Runny Nose no yes

Post-Nasal Drip no yes

Chronic Cough no yes

Dry Throat/Mouth no yes

Respiratory

Asthma no yes

Chronic Bronchitis no yes

Emphysema no yes

Vascular/Cardiovascular

Diabetes no yes

Heart Pain no yes

High Blood Pressure no yes

Vascular Disease no yes

Gastrointestinal

Diarrhea no yes

Constipation no yes

Genitourinary no yes

Genitals/Kidney/Bladder

Bones/Joints/Muscles no yes

Rheumatoid Arthritis no yes

Muscle Pain no yes

Joint Pain no yes

Lymphatic/Hematologic

Anemia no yes

Bleeding Problems no yes

Psychiatric no yes

If you answered YES to any of the above or have a condition not listed, please explain and list medications: