PAJKA EYE CENTER **Tech Name/Date: _____**

NAME_____DATE_____

MEDICAL HISTORY

ARE YOU BEING TREATED FOR:

YES NO

- ☐ ☐ DIABETES.....HOW LONG _____
- ☐ ☐ HIGH BLOOD PRESSURE
- ☐ ☐ HEART DISEASE OR HEART ATTACK
- ☐ ☐ ASTHMA,COPD,SHORTNESS OF BREATH
- ☐ ☐ STROKE
- ☐ ☐ KIDNEY STONES
- ☐ ☐ THYROID
- ☐ ☐ CANCER
- ☐ ☐ LUPUS, RHEUMATOID ARTHRITIS
- ☐ ☐ HIGH CHOLESTEROL
- ☐ ☐ HIV/AIDS
- ☐ ☐ HEPATITIS
- ☐ ☐ Have you had or been treated for:
  MRSA /BED BUGS/ SCABIES (Circle)
  Last Day Treated: _____

OTHER_____

FAMILY/SOCIAL HISTORY

- ☐ Blindness Mom/Dad/Brother/Sister
- ☐ Glaucoma Mom/Dad/Brother/Sister
- ☐ Diabetes Mom/Dad/Brother/Sister
- ☐ Heart Mom/Dad/Brother/Sister
- ☐ Cancer Mom/Dad/Brother/Sister
- ☐ Stroke Mom/Dad/Brother/Sister
- ☐ Arthritis Mom/Dad/Brother/Sister
- ☐ Other_____

Do you drink alcohol? Y / N

___ Occasionally
___1-2 per day
___3+ per day

Do you use Tobacco? Y / N

_1/2 pk per day cigar / cigarette / pipe
_1 pk per day chew tobacco (Circle)
_1+ pk per day

REVIEW OF SYSTEMS

Pregnant or nursing	☐ YES ☐ NO	_____
Fever /weight loss	☐ YES ☐ NO	_____
Ears, nose throat	☐ YES ☐ NO	_____
Heart	☐ YES ☐ NO	_____
Stomach, Bowel	☐ YES ☐ NO	_____
Respiratory (asthma, emphysema, COPD etc)	☐ YES ☐ NO	_____
Genital/Kidney HISTORY OF FLOMAX	☐ YES ☐ NO	_____
Skin	☐ YES ☐ NO	_____
Muscle, Joints, Bone	☐ YES ☐ NO	_____
Neurological (MS, stroke, etc)	☐ YES ☐ NO	_____
Psychiatric (depression, anxiety etc)	☐ YES ☐ NO	_____
Endocrine (diabetes, thyroid etc)	☐ YES ☐ NO	_____
Allergy/Immune System	☐ YES ☐ NO	_____
Blood/Lymph (cholesterol, anemia etc)	☐ YES ☐ NO	_____

Other_____

SURGICAL HISTORY

___Cataract Surgery Right Left Both Date_____
___ Lasers Right Left Both Date_____

LIST ANY OTHER SURGERIES:

_____Date_____
_____Date_____
_____Date_____
_____Date_____
_____Date_____
_____Date_____

_____ _____
John T. Pajka, MD (JTP) Brian W. Chinavare, MD (BWC)

_____ _____
Robert J. Derick, MD (RJD) Adam M. Nusgart, OD (AMN)

UPDATED by:
Date/Tech/ MD (initials)

_____/_____JTP BWC RJD AMN_____
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