MOVSHOVICH PC
DIABETIC EYE CENTER OF NEW JERSEY

596 Anderson Ave Suite 101, Cliffside Park, NJ 07010
Tel: 201-943-0022 Fax:201-313-9146
www.movshovichpc.com

PATIENT MEDICAL HISTORY RECORD

___________________________________ ___________________________ _______________ Gender ____ F___M

PATIENT NAME (LAST Name) (FIRST Name) BIRTHDATE

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, pulmonary disease, bowel disorder, neurological disorder, rheumatologic disorder or malignancy etc.?)

   _________ Yes ________No If YES, please explain:

   ____

2 Have you ever had any eye disease or injury (e.g. glaucoma, cataract, lazy eye, or retinal detachment?)

_________ Yes ________No If YES, please explain

____

3 Have you ever had any ocular treatment (surgery, laser, eye drops, or patching)?

_________ Yes ________No If YES, please explain

____

4 Do you wear, or have you ever worn eyeglasses or contact lenses? ________ Glasses _______Contact Lenses

5. Have you ever been hospitalized? _________ Yes ________No If YES, please explain and provide date(s) and reason:

____

6. Do you take any prescription medication including eyedrops ? _________ Yes ________No If YES, please explain

____

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7. Do you take any over-the-counter medications, vitamins or herbal supplements? _________ Yes ________No

If YES, please list: ____

8. Do you have any drug or food allergies? _____ Yes ______No If YES, please list:

REVIEW OF SYSTEMS

Do you currently have any of the following problems? Please Explain (if YES)

1. Chronic fever, unexpected weight loss/gain, fatigue? _______ Yes ________No

____

2.Ear/nose/throat problems (e.g. hearing loss, sinus, sore throat _________ Yes ________No

____

3.Heart problems (e.g. chest pain, irregular heartbeat) _______ Yes _______No

____

4.Respiratory problems (e.g. shortness of breath, wheezing, cough) _________ Yes________No

____

5.Gastrointestinal problems (e.g. heartburn, belly pain, diarrhea, nausea) ________ Yes ________No

____

6.Urinary problems (e.g. pain, frequent urination, blood in urine) _______ Yes _________No

____

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7. Skin problems (e.g. rashes, dermatitis, excessive dryness and itching) _________ Yes ________No

____

8. Musculoskeletal problems (e.g. muscle aches, joint pain or swelling) _________ Yes ________No

____

9. Neurological problems (e.g. numbness, weakness, headaches) _________ Yes ________No

____

10. Psychiatric problems (e.g. depression, anxiety) _________ Yes _________No

____

11. Endocrine problems (e.g. diabetes, thyroid) _________ Yes _________No

____

12. Blood Disorders (e.g. leukemia) _________ Yes _______No

____

FAMILY AND SOCIAL HISTORY

1. Do any medical or eye disease run in your family (e.g. diabetes, high blood pressure, glaucoma, cataract, macular degeneration)

   _______ Yes _______No If YES, please explain: ____

2. Do you smoke? ________ Yes________No If YES, how much? ___________________________

3. Do you drink alcohol? _______ Yes _______No If YES, how much? _____________________________

4. Any other medical issues not addressed above?____

___________________________________ Patient Signature

_____________________________________ Date

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