OMNI EYE SPECIALISTS
FOCUSED MEDICAL EYECARE
410-277-3937
OmniEyeSpecialists.com

**Windsor Mill:** 2925 Lord Baltimore Dr. Suite 300, Baltimore, MD 21244
**White Marsh:** 9106 Philadelphia Road Suite 314, Baltimore, MD 21237
**Glen Burnie:** 1600 Crain Highway Suite 601, Glen Burnie, MD 21061
**Catonsville:** 716 Maiden Choice Lane Catonsville, Maryland 21228
**Dundalk:** 1005 N. Point Blvd., Suite 704 Baltimore, Maryland 21224

# PATIENT MEDICAL HISTORY

Today's Date: _____

Patient Name: _____ Age: _____
(last name) (first name) (middle initial)

Primary Care Physician (Medical Doctor) _____
(last name) (first name)

Address of Medical Doctor: _____
(street) (city) (state) (zip code)

Telephone of Medical Doctor: (_____)_____ Fax: (_____) _____

Do you have, or have you had in the past, any of the conditions listed below?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Arthritis | ☐ | ☐ | Kidney Disease | ☐ | ☐ |
| Asthma | ☐ | ☐ | Nervous Problem | ☐ | ☐ |
| Chronic Lung Disease | ☐ | ☐ | Sinus Problems | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Stomach Problems | ☐ | ☐ |
| Emphysema | ☐ | ☐ | Thyroid Problems | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | Tuberculosis | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | Urinary Tract Infections | ☐ | ☐ |
| Hernias | ☐ | ☐ | Other Infectious Diseases | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Others: _____ | | |

Do you smoke? ☐ Yes ☐ No Were you ever a smoker? ☐ Yes ☐ No # of yrs you smoked_____

Are you allergic to any medications? ☐ Yes ☐ No If yes, what? _____

Do you suffer from seasonal allergies? ☐ Yes ☐ No If yes, what? _____

Please list all medications, eye drops, and vitamins you are currently taking and the dosage of each.

_____ _____

_____ _____

_____ _____

Do you or any of your family have a history of the following:

| | Yes | No | Self/Relationship to you | | Yes | No | Self/Relationship to you |
|---|---|---|---|---|---|---|---|
| Blindness | ☐ | ☐ | _____ | Cataracts | ☐ | ☐ | _____ |
| Lazy Eye | ☐ | ☐ | _____ | Eye Disease | ☐ | ☐ | _____ |
| Glaucoma | ☐ | ☐ | _____ | Vascular Disease | ☐ | ☐ | _____ |

List all surgeries you have had in the past 10 years: _____

Do you have a Living Will? ☐ Yes ☐ No _____

*For Doctor's use only:* **********

Chief Complaint: _____