MOVSHOVICH PC

DIABETIC EYE CENTER OF NEW JERSEY

596 Anderson Ave Ste. 101, Cliffside Park, NJ 07010
Tel: 201-943-0022 Fax: 201-313-9146
WWW.MOVSHOVICHPC.COM

PATIENT MEDICAL HISTORY RECORD

_____ Gender M F
PATIENT NAME (LAST, FIRST) BIRTHDATE (MM/DD/YY)

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 wore, eyeglasses or contact lenses? Glasses Contact Lenses

5. Have you ever been hospitalized?

   Yes No If YES, please provide date and reason: _____

_____

6. Do you take any prescription medications, including eye drops?

   Yes No If YES, please list:_____

_____

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: _____

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Review of Systems

Do you currently have any of the following problems			**Please Explain (if YES)**
Chronic fever, unexpected weight loss/gain, fatigue	Yes	No	_____
Ear/nose/throat problems (e.g. hearing loss, sinus, sore throat)	Yes	No	_____
Heart problems (e.g. chest pain, irregular heartbeat)	Yes	No	_____
Respiratory problems (e.g. shortness of breath, wheezing, cough)	Yes	No	_____
Gastrointestinal problems (e.g. heartburn, belly pain, diarrhea, nausea)	Yes	No	_____
Urinary problems (e.g. pain, frequent urination, blood in urine)	Yes	No	_____
Skin problems (e.g. rashes, dermatitis, excessive dryness and itching)	Yes	No	_____
Musculoskeletal problems (e.g. muscle aches, joint pain or swelling)	Yes	No	_____
Neurological problems (e.g. numbness, weakness, headaches)	Yes	No	_____
Psychiatric problems (e.g. depression, anxiety)	Yes	No	_____
Endocrine problems (e.g. diabetes, thyroid)	Yes	No	_____
Blood Disorders (e.g. leukemia)	Yes	No	_____

Family and Social History

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:_____

_____

Do you smoke? Yes No If YES, how much? _____

Do you drink alcohol? Yes No If YES, how much? _____

Any other medical issues not addressed above? _____

_____

_____

_____ _____

Patient Signature Date