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
**E-mail :** movshovichpc@gmail.com
**Website :** 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