

Madison Eye Care, LLC

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MEDICAL HISTORY

Patient Name: _____ Date: _____

Primary Care Physician: _____ Date of Last Exam: ___/___/___

Telephone:(____) _____ - _____ Address _____

1. **Are you currently infected with:** Cold virus, flu, HIV/AIDS, measles, chicken pox, herpes zoster, or any other infectious disease?

2. **Allergies to Medications: Yes/ No.** If yes, please list:

3. **Current Medications:**

4. **Females:** Are you pregnant or nursing? **YES/NO** How many months? _____

5. **Parents fill out for your child:** Prematurity, congenital conditions, Downs syndrome, autism, developmentally delayed, cerebral palsy, learning disabled, or other:

Are you being treated for any of the following disorders? (If yes, please list):

Dermatologic Disorders (rash, skin disease, other) **Yes/No**

Ear/Nose/Throat (Sinus, seasonal allergies, hearing problems) **Yes/No**

Cardiovascular (High blood pressure, cholesterol, heart disease) **Yes/No**

Respiratory (asthma, COPD, emphysema) **Yes/No**

Gastrointestinal (Digestive Disorders etc.) **Yes/No**

Endocrine (Diabetes, Thyroid, other) **Yes/No**

Neurologic (MS, Cerebral Palsy, stroke, headache) **Yes/No**

Cancer **Yes/No**

Musculoskeletal (Arthritis, muscle disease, other) **Yes/No**

Psychiatric Well-Being (Depression, anxiety, other) **Yes/No**

Genito-urinary/Reproductive (Bladder/urinary problems, hormone imbalance) **Yes/No**

History of Surgery: (Please list dates):

History of Eye Surgery (dates):

Family Medical History (systemic and ocular):

Patient Signature: _____ Date: _____