St. Luke's
at The Villages

OFFICE AND SURGICAL CENTER:
1050 Old Camp Road, Bldg #230
The Villages, FL 32162

TOLL FREE: 800.282.9905
LOCAL: 352.350.8484
FAX: 352.751.9850

WEB: StLukesEye.com

MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL.

For your personal privacy,
please close this form once it is completed.

St. Luke's at The Villages

Chart No: _____

Date: _____

Technician Use Only
Reviewed By: _____ Date: _____

MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL

Patient: _____ Age: ____ Marital Status: M S D W
Last Name First Name M

FAMILY DOCTOR: _____ Phone: (_____)_____
Name

Address: _____
Street City State Zip

Date of Last Visit: _____ Reason for Visit: _____

Tests Performed (please list): _____

PAST OCULAR HISTORY:

Previous History of Eye Treatment or Exams: _____

_____

What problems are you having with your eyes? _____

PAST/PRESENT MEDICAL HISTORY: Please check Yes or No for each of the following.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Alzheimer's	☐	☐	Carotid Artery Disease	☐	☐	Heart Disease	☐	☐	Pneumonia
☐	☐	Anemia	☐	☐	Claustrophobia	☐	☐	Hiatal Hernia	☐	☐	Psychiatric Disorder
☐	☐	Angina	☐	☐	Congestive Heart Failure	☐	☐	High Blood Pressure	☐	☐	Radiation/Chemo
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Irregular Heartbeat/Pacer	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Diagnosed Memory Loss	☐	☐	Kidney Disease	☐	☐	Seizures
☐	☐	Bleeding Problems	☐	☐	Diverticulosis	☐	☐	Liver Disease/Hepatitis	☐	☐	Stroke
☐	☐	Blood Diseases	☐	☐	Emphysema	☐	☐	MRSA	☐	☐	Thyroid Disorder
☐	☐	Bronchitis	☐	☐	Heart Attack	☐	☐	Phlebitis	☐	☐	Tuberculosis
									☐	☐	Ulcers

Other _____

WOMEN: ARE YOU

Yes	No		Yes	No	
☐	☐	Pregnant/Trying to Get Pregnant	☐	☐	Nursing
☐	☐	Taking Oral Contraceptives			

HAVE YOU OR A FAMILY MEMBER BEEN DIAGNOSED WITH THE FOLLOWING?

Yes	No		Yes	No	
☐	☐	Creutzfeldt-Jakob Disease	☐	☐	Gerstmann-Straussler-Scheinker Disease
☐	☐	Fatal Familial Insomnia	☐	☐	Have you ever received injections of hormones to increase your height?

HOSPITALIZATIONS: Please list the date of any relevant surgeries or hospitalizations.

Yes	No		Yes	No		Yes	No	
☐	☐	Appendectomy_____	☐	☐	Heart _____	☐	☐	Prostate_____
☐	☐	Back_____	☐	☐	Hernia _____	☐	☐	Stomach/Abdomen_____
☐	☐	Cancer _____	☐	☐	Hysterectomy _____	☐	☐	Thyroid/Neck _____
☐	☐	Eye Surgery_____	☐	☐	Lungs_____	Other _____		
☐	☐	Gallbladder _____	☐	☐	Mastectomy_____	Other _____		

Physician Use Only: Reviewed By: _____ Date: _____

Technician Use Only
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Chart No: _____

Date: _____

Patient: _____
Last Name First Name M

PRESENT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS:

Please list name, dose and frequency or attach a list. _____

_____

ALLERGIES TO MEDICATIONS:

☐ No Known Allergies Latex Sensitivity: No ☐ Yes ☐

Please list: _____

_____

FAMILY HISTORY:

	Living? No	Living? Yes	Medical Problems or Cause of Death
Mother	☐	☐	_____
Father	☐	☐	_____
Sister/Brother	☐	☐	_____

Please list any history of eye disease or eye surgery in your family: _____

_____

SOCIAL HISTORY: Do (Did) you:

No	Yes	Former			
☐	☐	☐	Smoke	How much per day? _____	For how many years? _____
☐	☐	☐	Drink Alcohol	How much per day? _____	
☐	☐	☐	Recreational Drug Use	How much per day? _____	

REVIEW OF SYSTEMS: Do you have these now? If yes, circle condition and explain.

No	Yes		
☐	☐	**Skin:** Psoriasis/Rash/Shingles	_____
☐	☐	**Head:** Headache/Migraines/Temporal Arteritis	_____
☐	☐	**Eyes:** Cataract/Glaucoma/Retina	_____
☐	☐	**Ears:** Hearing Loss/Aids	_____
☐	☐	**Nose/Mouth/Throat:** Dentures/Sinus	_____
☐	☐	**Neck:** Restriction of Movement/Difficulty swallowing	_____
☐	☐	**Pulmonary:** Cough/Shortness of Breath/Wheeze	_____
☐	☐	**CV:** Chest Pain/Palpitations	_____
☐	☐	**GI:** Ulcers/Pain	_____
☐	☐	**MS:** Leg Cramps/Swelling	_____
☐	☐	**Neuro:** Tremor/Speech Problems	_____
☐	☐	**Psych:** Anxiety/Depression/Insomnia/Panic Attacks	_____

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