EYE CENTER on CAPITOL HILL

650 Pennsylvania Ave SE
Suite 270
Washington, DC, 20003
Tel: (202) 544-1900
Fax: (202) 547-4257
www.butruscapitoleye.com

SALIM I. BUTRUS, M.D., P.C.

PAST MEDICAL HISTORY FORM

(Please print clearly)

Patient Name: _____ Reviewed: _____

Date: _____ Date: _____

PAST MEDICAL HISTORY

Do you have any medical problems? ☐ None

High Blood Pressure	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Insulin	Oral Meds	Diet
Kidney Disease	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Sarcoidosis	☐ Yes	☐ No
AIDS / HIV	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No

Other (please list) _____

Do you take any medication? ☐ None

Aspirin or Ibuprofen	☐ Yes	☐ No
Blood Thinner	☐ Yes	☐ No

If yes please list _____

_____

_____

Other _____

_____

_____

_____

_____

PAST SURGICAL HISTORY

Please list any operations you have had. ☐ None

_____

_____

_____

_____

_____

_____

_____

What drugs are you allergic to? ☐ No known Allergies

_____

_____

_____

_____

_____

_____

_____

REVIEW OF SYSTEMS

Do you have any of these symptoms? ☐ No Problems

General

Depression	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Weight Loss / Gain	☐ Yes	☐ No

Ears, Nose, Mouth & Throat

Loss of Hearing	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No

Cardiovascular

Chest pain	☐ Yes	☐ No
Irregular heart beat	☐ Yes	☐ No
Poor circulation	☐ Yes	☐ No

Genito-Urinary

Bood in Urine	☐ Yes	☐ No
Pain when Urinating	☐ Yes	☐ No

Neurological

Weakness	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Headaches	☐ Yes	☐ No

Respiratory

Shortness of Breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Persistent Cough	☐ Yes	☐ No

Gastrointestinal

Stomach Pain	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No

Musculoskeletal

Muscle Aches	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No
Swollen Joint	☐ Yes	☐ No

Skin

Escessive Dryness	☐ Yes	☐ No
Rash	☐ Yes	☐ No

Cardiovascular

Bleeding Problems	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Excessive Bleeding with Surgery or Dental Work	☐ Yes	☐ No

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PAST MEDICAL HISTORY FORM 2

(Please print clearly)

Patient Name: _____ Reviewed: _____

Date: _____ Date: _____

FAMILY HISTORY

Please check (√) if your blood relatives have the following ☐ None

DISEASE	RELATIONSHIP TO YOU
☐ Heart Disease	
☐ High Blood Pressure	
☐ Stroke	
☐ Diabetes	
☐ Kidney Disease	
☐ Other (please list)	

SOCIAL HISTORY

Please check (√) "Yes" or "No"
Do you use:

Alcohol	☐ Yes	☐ No
Tobacco	☐ Yes	☐ No
Illegal Drugs	☐ Yes	☐ No
I.V. Drugs	☐ Yes	☐ No

PAST EYE HISTORY

Do you have any of the following eye diseases? ☐ None

Cataract	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Diabetic Eye Disease	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No
Crossed Eyes	☐ Yes	☐ No
Blindness	☐ Yes	☐ No
Corneal Disease	☐ Yes	☐ No
Other (please list)		

PAST EYE SURGERY OR LASER

Have you had any eye or laser surgery? ☐ None

Surgery or Laser	Dates

What Eye Drops or Ointment do you use? ☐ None

What Eye Drops or Ointment are you Allergic to? ☐ None

Eye Review of Systems ☐ None

Do you have any of the following?

- ☐ Poor Night Vision
- ☐ Light Sensitivity
- ☐ Dry Eyes
- ☐ Excessive Watering
- ☐ Episodic Loss of Vision
- ☐ Other (please list) _____

Family Eye History ☐ None

Please Check (√) if your Blood Relatives have the following:

- ☐ Cataract
- ☐ Glaucoma
- ☐ Diabetic Eye Disease
- ☐ Macular Degeneration
- ☐ Crossed Eyes
- ☐ Blindness
- ☐ Corneal Disease
- ☐ Other (please list) _____