Persila V. Mertz, MD, PC

115 E. Main St

Ephrata, PA 17522

Medical History Form

Name:_____ Date of Birth:_____

1. Do you wear eye glasses? Y N
2. Do you wear contact lenses? Y N
3. Have you had any eye problems? Y N (please circle any that apply)
   Cataracts, Glaucoma, Infection, Uveitis
   Other:_____
4. Do you experience any of the following? Y N (please circle any that apply)
   Temporary loss of vision, Double vision, flashing lights, Floaters
   Other:_____
5. Have you had any eye surgery? Y N Explain:_____
6. Please list any surgeries you have had including childhood to present time_____
   _____
   _____
7. Do you have any medical diseases? Y N (please circle any that apply)
   Diabetes, high blood pressure, thyroid, arthritis, heart disease, stroke, cancer, lupus, asthma, prostate
   Other: _____
8. Are you allergic to any medications? Y N
   Please list:_____
9. Are any of the following common in your family? (please circle any that apply)
   Glaucoma Retinal Detachment Macular Degeneration Diabetes
10. Do you smoke? Y N _____packs/day
11. Do you drink Alcohol? Y N _____drinks/day
12. Do you take any medications? Y N
    A. Eye Medication:_____
    B. Other Medications:_____
       _____
       _____
    C. Are you currently, or have you ever taken **FLOMAX** or other prostate medications? Y N

I certify that I have read and answered all the questions to the best of my ability. I understand that this information, and any other information discussed during my appointment will remain confidential and will not be released from this office without a signed records release. I understand that only the people I have named on this paper will be allowed to have access to my health information.

_____ _____

Signature Date

(over)

Review of Systems

Have you had any of the following? Please circle.

Constitutional
Fever
Fatigue
Night sweats
Weight loss/gain

HEENT
Vision changes
Hearing changes
Ear aches
Ringing in ears
History of tubes in ears
Headache
Nosebleeds
Stuffy/runny nose
Loose teeth
Hoarseness
Sore throat

Respiratory
Shortness of breath
New cough
Pain with a deep breath

Cardiovascular
Chest pain
Racing heart
Heart skipping beats
Heart murmur
Inability to lay flat in bed

Vascular
Leg pain
Swelling
Varicose veins

Gastrointestinal
Vomiting
Diarrhea
Constipation
Stomach pain
History of gall stones or hepatitis

Genitourinary
Painful/difficult urination
Blood in urine
Frequent urination

Metabolic/Endocrine
Cold/heat intolerance

Neuro/Psychiatric
Dizziness/loss of balance
Tingling or numbness
Unusual memory loss
Emotional disturbances
Fainting
History of head injury
Mood changes

Dermatological
Rashes
Itching
Dry skin
Changes in hair or nails
Changing moles

Musculoskeletal
Back pain
Joint pain
Muscle stiffness/weakness
Recent muscle cramps

Hematological
Bleeding
Easy bruising

Immunological
Recent food allergic reactions
Recent environmental allergic reactions

Physician Signature: _____
Date: _____