*Efraim Duzman M.D.*
*Eran Duzman M.D.*
Medical & Health History

**Patient Name** _____ **Date** ___ / ___ / ___ **Age**_____

**Chief complaint(S)**_____

_____

## Please answer each question by marking "yes" or "no"

Yes No **Are you in good general health?**

**When was your last physical examination ?** _____

Yes No **Has there been a change in your health within the past year ?**

Yes No **Are you now under the care of a physician?**

**If yes please explain** _____

Yes No **Have you been hospitalized or had a serious illness within the past five years ? Explain** _____

Yes No **Have you ever had any of the following medical condition (If yes, please Circle the condition**

**Rheumatic Fever, Heart Murmur , Anemia , Epilepsy, Stroke , Diabetes, High Blood pressure, Thyroid condition, Kidney disease , Bleeding disorders Cancer, Others , ( Please explain)** _____

Yes No **Are you currently taking prescription medication? If Yes, please list.**

1._____ 2._____ 3._____

4._____ 5._____ 6_____

Yes No **Are you sensitive or allergic to any drugs ? If Yes , please list**

_____ _____ _____

Yes No **Do you have any lung disease or breathing difficulties ?**

Yes No **Do you have any heart trouble ? ( Angina ? heart failure ? rhythm disorders?)**

Yes No **Do you have chest pain or cough on exertion ?**

*Efraim Duzman M.D.*
*Eran Duzman M.D.*

## Medical history *(Page two, continuation from previous page)*

Yes No **Do you have any problem with your kidneys ?**

Yes No **Do you have any problems with your liver ? Did you have Jaundice or Hepatitis ?**

Yes No **Do you have any problems with blood clotting or a bleeding disorder ?**

Yes No **Are you subject to nervous disorders ?**

Yes No **Have you ever had psychiatric treatment ?**

Yes No **Have you ever been treated for alcohol or drug abuse ?**

Yes No **Do you smoke ? if Yes how many cigarettes per day _____ ?**

Yes No **Have you been diagnosed as having positive HIV Test ?**

Yes No **Have you ever experienced a severe and unexpected reaction to a medical treatment ?**

**If Yes , please specify** _____

Yes No **WOMEN , Are you currently pregnant or planning to become pregnant ?**

**If pregnant , how many months?** _____ .

Yes No **Do you have any other condition disease or problem not listed above that you think we should know about ? If yes Explain :**

_____

**I Confirm as true the above medical information . I Understand that this information is confidential and that it is being recorded to improve my medical care.**

**Signature :** _____ **Date :** _____

**Signature** ( office personnel): _____ **Date :** _____

# Medical History

## Ophthalmic History

Have you ever experienced any of the following problems?

| | NO | YES | | NO | YES |
|---|---|---|---|---|---|
| Crossed Eyes | ☐ | ☐ | Glaucoma | ☐ | ☐ |
| Lazy Eye | ☐ | ☐ | Cataract | ☐ | ☐ |
| Eye Trauma | ☐ | ☐ | Retinal Disease | ☐ | ☐ |
| Other Eye Problems | ☐ | ☐ | Please specify | | |

If you answered YES to any of the above, please explain _____

_____

Are you currently using any eye medications? ☐ NO ☐ YES

If yes, please specify _____

Do you wear corrective glasses or contact lenses? ☐ NO ☐ YES

If yes, please specify _____

Have you had previous eye treatment or surgery? ☐ NO ☐ YES

If yes, please specify _____ Date _____

_____ Date _____

_____ Date _____

_____

**I certify that the information furnished is true and correct.**

**Patient Signature** _____ **Date** _____

*Efraim Duzman, M.D. • 4605 Barranca Pkwy, Suite 100 • Irvine, California 92714 • (714) 733-2002*