PATIENT HISTORY

Date ___________________

Name _______________________________________ D.O.B. ____/____/____ Date of **Last Eye Exam** ____/____/____

List any **medications** you take (Rx and over-the-counter): ______________________________

List all major **illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): ______________________________

List any **surgeries** you have had (heart, appendix, knee, etc.) ______________________

List any **medications** you are **ALLERGIC** to: __________

Do you currently have any problems with the following? If YES, mark items applicable.

Category	Response	Items
EYES	❑ YES ❑ NO	❑ poor vision ❑ eye pain ❑ tearing ❑ redness ❑ other
GENERAL, CONSTITUTION	❑ YES ❑ NO	❑ fever ❑ weight loss ❑ weight gain ❑ unusual tiredness ❑ other
EARS, NOSE, THROAT	❑ YES ❑ NO	❑ hard of hearing ❑ earache ❑ cough ❑ sore throat ❑ dry mouth ❑ stuffy nose ❑ other
CARDIOVASCULAR	❑ YES ❑ NO	❑ high blood pressure ❑ racing pulse ❑ heart attack ❑ chest pain ❑ stroke ❑ other
RESPIRATORY	❑ YES ❑ NO	❑ congestion ❑ wheezing ❑ asthma ❑ shortness of breath ❑ bronchitis ❑ emphysema ❑ other
GASTROINTESTINAL	❑ YES ❑ NO	❑ stomach upset ❑ diarrhea ❑ constipation ❑ hernia ❑ ulcers ❑ heartburn ❑ other
GENITAL, KIDNEY, BLADDER	❑ YES ❑ NO	❑ painful/frequent urination ❑ kidney disease ❑ prostate disease ❑ other
MUSCLES, BONES, JOINTS	❑ YES ❑ NO	❑ joint pain ❑ stiffness ❑ swelling ❑ cramps ❑ arthritis ❑ other
ALLERGIC / IMMUNOLOGICAL	❑ YES ❑ NO	❑ sneezing ❑ swelling ❑ redness ❑ itching ❑ H.I.V. ❑ hives ❑ lupus ❑ other
BLOOD / LYMPH	❑ YES ❑ NO	❑ bleeding ❑ cholesterolemia ❑ anemia ❑ other
SKIN	❑ YES ❑ NO	❑ pimples ❑ warts ❑ growths ❑ rash ❑ other
NEUROLOGICAL	❑ YES ❑ NO	❑ numbness ❑ headache ❑ seizures ❑ paralysis ❑ other
PSYCHIATRIC	❑ YES ❑ NO	❑ anxiety ❑ depression ❑ insomnia ❑ other
ENDOCRINE	❑ YES ❑ NO	❑ diabetes ❑ hypothyroid ❑ other
FEMALES	❑ YES ❑ NO	❑ pregnant ❑ nursing

YOUR OCULAR HISTORY - HAVE YOU EVER BEEN DIAGNOSED WITH:

YES	NO	Condition	Details
❑	❑	Cataracts	(Cataract Surgery Dates: Right_________ Left_________)
❑	❑	Retinal Disease	(Retinal Surgery Dates: Right_________ Left_________)
❑	❑	Injury	Explanation: ______________________
❑	❑	Other eye disorder	Explanation: ______________________

YES	NO	Condition
❑	❑	Glaucoma
❑	❑	Iritis
❑	❑	Dry Eyes
❑	❑	Corneal Disease

FAMILY HISTORY (MOTHER, FATHER, GRANDPARENT, SIBLING)

Has any member of your family had these diseases?

(Mark all that apply)

YES	NO	UNKNOWN	Disease
❑	❑	❑	..........Blindness
❑	❑	❑	..........Cataract
❑	❑	❑	..........Glaucoma
❑	❑	❑	..........Diabetes
❑	❑	❑	..........Hypertension
❑	❑	❑	..........Heart
❑	❑	❑	..........Stroke
❑	❑	❑	..........Cancer
❑	❑	❑	..........Thyroid
❑	❑	❑	..........Arthritis

Other inheritable disease: ______

SOCIAL HISTORY

YES	NO	Question
❑	❑	Does your vision limit any activities of daily living? (driving, reading, sports, work, etc.)
❑	❑	Have you ever had a blood transfusion?
❑	❑	Do you drink alcohol? If yes, how much? ________
❑	❑	Do you smoke? If yes, how much? ________ How many years? ________

Physician's Signature ______________________________ Date ______________

Update: Physician's Initials ______________________________ Date ______________

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