

NEW PATIENT HISTORY RECORD

Name: _____ Date: _____

PAST EYE HISTORY (List any diagnosed eye illness or surgeries) _____

CURRENT EYE MEDICATIONS (List all eye drops or ointments) _____

PAST MEDICAL HISTORY

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
TUBERCULOSIS	_____	_____	HIGH BLOOD PRESSURE	_____	_____
CANCER	_____	_____	KIDNEY DISEASE	_____	_____
DIABETES	_____	_____	THYROID DISEASE	_____	_____
BLOOD DISORDERS	_____	_____	LUNG DISEASE	_____	_____
HEART DISEASE	_____	_____	NEUROLOGICAL DISORDERS	_____	_____
OTHER (DESCRIBE) _____					

MAJOR SURGERIES (DESCRIBE) _____

MEDICATIONS (List all oral medications) _____

ALLERGIES (List all known drug or substance allergies) _____

FAMILY HISTORY (Please list any family history of eye diseases or illnesses) _____

SOCIAL HISTORY

DO YOU SMOKE? () YES () NO HOW MUCH? _____
DO YOU DRINK ALCOHOL? () YES () NO HOW MUCH? _____
HAVE YOU EVER USED DRUGS? () YES () NO IF YES, EXPLAIN _____
HAVE YOU EVER HAD A BLOOD TRANSFUSION? () YES () NO

REVIEW OF SYSTEMS (Do you have any of the following problems?)

CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE	() YES () NO	_____
EAR/NOSE/THROAT PROBLEMS (hearing loss, sinus problems, etc)	() YES () NO	_____
HEART PROBLEMS (chest pain, irregular heart beat, etc)	() YES () NO	_____
RESPIRATORY PROBLEMS (shortness of breath, wheezing, coughing)	() YES () NO	_____
GASTROINTESTINAL PROBLEMS (heartburn, abdominal pain, etc)	() YES () NO	_____
URINARY PROBLEMS (pain or discomfort, blood in urine, etc)	() YES () NO	_____
SKIN PROBLEMS (rashes, excessive dryness, etc)	() YES () NO	_____
MUSCULOSKELETAL PROBLEMS (muscle aches, joint pain, etc)	() YES () NO	_____
NEUROLOGIC PROBLEMS (numbness, weakness, headaches, paralysis)	() YES () NO	_____
PSYCHIATRIC PROBLEMS (depression, anxiety, etc)	() YES () NO	_____
ALLERGIES (hay-fever, sinus problems, runny nose, etc)	() YES () NO	_____

Completed By: _____ Relationship: _____

HISTORY REVIEWED () CHANGES () CHANGES AS NOTED PHYSICIAN: _____ DATE: _____

