PATIENT HISTORY RECORD

Name: _____ DOB: _____ Date: _____

PAST EYE HISTORY (Check all that apply)

( ) GLARE ( ) POOR NIGHT VISION ( ) TIRED EYES ( ) MACULAR DEGENERATION
( ) GLAUCOMA ( ) DISCHARGE/MUCOUS ( ) BLURRED VISION ( ) CONTACT LENS DISCOMFORT
( ) DRY EYES ( ) PROBLEMS READING ( ) FLOATERS ( ) RETINAL DETACHMENT/TEAR/HOLE
( ) CATARACTS ( ) FLASHES OF LIGHT ( ) ITCHING/BURNING ( ) HEADACHES
( ) EYE PAIN ( ) OTHER _____

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

MEDICAL HISTORY	YES	NO		YES	NO
TUBERCULOSIS	____	____	HIGH BLOOD PRESSURE	____	____
CANCER	____	____	KIDNEY DISEASE	____	____
THYROID DISEASE	____	____	LUNG DISEASE	____	____
BLOOD DISORDERS	____	____	NEUROLOGICAL DISORDERS	____	____
HEART DISEASE	____	____	DIABETES TYPE 1 / TYPE 2	____	____
PREGNANT (CURRENTLY)	____	____	-LAST A1C READING_____		
OTHER (DESCRIBE) _____			-BLOOD SUGAR READING _____		

MAJOR SURGERIES (DESCRIBE)_____

MEDICATION / DOSAGE / FREQUENCY / ROUTE ( ) NONE

_____ _____

_____ _____

_____ _____

ALLERGIES (List all known drug or substance allergies) ( ) NONE _____
_____

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

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 currently 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 ( ) NO CHANGES ( ) CHANGES AS NOTED PHYSICIAN: _____ DATE: _____
( ) NO CHANGES ( ) CHANGES AS NOTED PHYSICIAN: _____ DATE: _____
( ) NO CHANGES ( ) CHANGES AS NOTED PHYSICIAN: _____ DATE: _____