PATIENT HISTORY RECORD

Name: ____ DOB: ____________________ Date: _____________________

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

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

MEDICAL HISTORY

	YES	NO		YES	NO
TUBERCULOSIS	____	____	HIGH BLOOD PRESSURE	____	____
CANCER	____	____	KIDNEY DISEASE	____	____
DIABETES	____	____	THYROID DISEASE	____	____
BLOOD DISORDERS	____	____	LUNG DISEASE	____	____
HEART DISEASE	____	____	NEUROLOGICAL DISORDERS	____	____
PREGNANT (CURRENTLY)	____	____			

OTHER (DESCRIBE) ____

MAJOR SURGERIES (DESCRIBE) ____

MEDICATION/ DOSAGE / FREQUENCY / ROUTE

____ ____

____ ____

____ ____

ALLERGIES (List all known drug or substance allergies) ____
____

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: ______________