PATIENT HISTORY FORM

Thank you for choosing our practice. Date______________________

Last name_________________ First__________________ M.I.__ E-Mail___________________

Date of Birth______________ Sex_____ How did you hear about us?_____________________

Address_________________________ City____________ State____________ ZIP________

Phone: Home__________________ Work__________________ Cell______________________

Social Security #_______________ Occupation______________ Insurance________________

Were you referred here by another Doctor? ☐ Yes ☐ No If yes which Dr.?________________

EYE HISTORY

Do you currently wear ☐ Glasses ☐ Contact lenses ☐ Neither

Do you have visual difficulty when reading? ☐ Yes ☐ No

Do you have visual difficulty when driving or seeing far away ☐ Yes ☐ No

Are you currently using any prescription or over the counter medications or drops for your eyes? ☐ Yes ☐ No If yes, please list:____

Have you ever had eye surgery? ☐ Yes ☐ No If yes, please describe:

☐ Right Eye – Type of surgery:___________________________________ Date____________

☐ Left Eye – Type of surgery:____________________________________ Date____________

Have you ever injured your eyes? ☐ Yes ☐ No If yes, please describe ___________________

____

Have you ever had or do you have any of the following eye conditions?

	Currently	Past	Never		Currently	Past	Never
Glaucoma	☐	☐	☐	Halos	☐	☐	☐
Macular Degeneration	☐	☐	☐	Light sensitivity	☐	☐	☐
Cataracts	☐	☐	☐	Redness	☐	☐	☐
Retinal tear or detachment	☐	☐	☐	Itching	☐	☐	☐
Lazy eye/eye patching	☐	☐	☐	Burning	☐	☐	☐
Eye pain	☐	☐	☐	Dryness	☐	☐	☐
Blurred, decreased vision	☐	☐	☐	Sandy/gritty eye(s)	☐	☐	☐
Plaquenil Use	☐	☐	☐	Foreign body sensation	☐	☐	☐
Flashes of light in eye(s)	☐	☐	☐	Discharge	☐	☐	☐
Floating dark spots in eye(s)	☐	☐	☐	Crusting on eyelid	☐	☐	☐
Double Vision	☐	☐	☐	Drooping eyelid	☐	☐	☐

Other____

MEDICAL HISTORY

Are you currently being treated for any of the following? ☐ **High Blood Pressure** ☐ **Diabetes**

☐ Heart Disease ☐ Stroke ☐ Arthritis ☐ Other____________________________________

Have you ever been treated for any other serious illness or medical conditions or have had any hospitalizations or surgery? If Yes, please explain_____________________________________

____

____

____

Please list any medications that you take, prescription or over the counter or herbal remedies

____

____

____

Do you have any: ☐ **Drug Allergies?** If yes, please list and explain reaction(s): _______________

____

☐ **Seasonal Allergies?** If yes, please list and explain reaction(s) and if you take anything for them.____

____

Review of Systems: Are you currently experiencing problems with any of the following?

			If yes, please explain
Chronic Fever, sudden weight loss/gain, fatigue	☐ Yes	☐ No	________________________
Heart (e.g. chest pain, irregular heartbeat, hypertension)	☐ Yes	☐ No	________________________
Respiratory (e.g. cough, wheezing, shortness of breath)	☐ Yes	☐ No	________________________
Ear/nose/throat (e.g. hearing loss, sinus, sore throat)	☐ Yes	☐ No	________________________
Gastrointestinal (e.g. heartburn, belly pain, diarrhea)	☐ Yes	☐ No	________________________
Urinary (e.g. pain, frequent urination, blood in urine)	☐ Yes	☐ No	________________________
Skin problems (e.g. dry skin, rashes, dermatitis, itching)	☐ Yes	☐ No	________________________
Musculoskeletal (e.g. muscle aches, joint pain or swelling)	☐ Yes	☐ No	________________________
Endocrine (e.g. diabetes, thyroid)	☐ Yes	☐ No	________________________
Hematologic/lymphatic (e.g. leukemia, enlarged glands)	☐ Yes	☐ No	________________________
Psychiatric (e.g. depression, anxiety, confusion)	☐ Yes	☐ No	________________________
Neurological (e.g. numbness, weakness, headaches)	☐ Yes	☐ No	________________________

Social History

Martial Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ Rarely ☐ Socially/moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Former use ☐ Current, how much?_________________________

Use of recreational drugs: ☐ Never ☐ Former use ☐ Current, what and how much?_______

____

Family Medical/Eye History(e.g. diabetes, glaucoma, retinal tears/detachment, macular degen)

	Approx. Age at diagnosis	Medical/Eye Disease
Father	_____________	____
Mother	_____________	____
Siblings	_____________	____
	_____________	____
Children	_____________	____
	_____________	____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status.

____   _______________________________

Signature of patient (or guardian, if minor)   Date