

PATIENT HEALTH HISTORY

Thank you for choosing our practice. To better serve you, please fill out the information below to the best of your ability.

Date _____ Reason for today's visit _____

Patient Name _____ Sex _____ Birth date _____

Soc Sec # _____ Primary Care Physician _____

Address _____

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____ Email _____

EYE HISTORY

Do you currently wear Glasses Contact Lenses Neither

Do you have visual difficulty when reading? No Yes

Do you have visual difficulty when driving? No Yes

Are you currently using any prescription or non-prescription medication for your eye(s)? No Yes

If yes, please list _____

Have you ever had eye surgery? No Yes

If yes, please describe:

Right Eye Type of surgery _____ Date _____

 Type of surgery _____ Date _____

Left Eye Type of surgery _____ Date _____

 Type of surgery _____ Date _____

Have you ever injured your eye? No Yes

If yes, please describe _____

Have you ever had any of the following eye conditions?

	Check here if you are currently experiencing this condition			Check here if you are currently experiencing this condition			
Glaucoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Halos	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Light sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Cataracts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Redness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Retinal tear or detachment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Itching	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Lazy eye/wandering eye	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Burning	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Eye pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Dryness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Sandy/gritty sensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Decreased vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Foreign body sensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Double vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Discharge	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Flashes of light in eye(s)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Crusting on eyelid	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Floating dark spots in eye(s)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Drooping eyelid	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>

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 a serious illness or medical condition? No Yes

If yes, please explain _____

Have you had any hospitalization or surgery? No Yes

If yes, please explain _____

Please list any medications that you take, prescription or non-prescription:

Do you have:

Drug allergies No Yes Please list _____

Food allergies No Yes Please list _____

Latex allergies No Yes

Patient Name _____

MEDICAL HISTORY (Cont.)

Review of systems:

Are you currently experiencing problems with any of the following?

If yes, please explain

- Sudden weight gain or loss No Yes _____
- Chronic fever or chronic fatigue No Yes _____
- Heart No Yes _____
(example: chest pain, angina, irregular heart beat)
- Respiratory No Yes _____
(example: coughing, wheezing, shortness of breath, asthma)
- Ear/Nose/Throat No Yes _____
(example: sore throat, sinus problem, earache, hearing loss)
- Gastrointestinal No Yes _____
(example: abdominal pain, heartburn, bowel problems, vomiting)
- Urinary No Yes _____
(example: pain when urinating, blood in urine)
- Hematologic/Lymphatic No Yes _____
(example: blood disorders, bruising, cuts heal slowly, enlarged glands)
- Endocrine No Yes _____
(example: thyroid problems)
- Integumentary No Yes _____
(example: rashes, dry skin)
- Musculoskeletal No Yes _____
(example: joint pain, stiffness or swelling, muscle pain or weakness)
- Neurological No Yes _____
(example: numbness, headache, seizures, paralysis)
- Psychiatric No Yes _____
(example: depression, anxiety, insomnia, confusion)
- Allergic/Immunologic No Yes _____
(example: reaction to food or drugs, allergies, hay fever)

Social History:

- Marital status: Single Married Separated Divorced Widowed
- Use of alcohol Never Rarely Moderate Daily How much? _____
- Use of tobacco Never Previously, but not in past _____ years Yes _____ packs/day

Family Medical History:

	Age	Medical/Eye Disease	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____
Spouse	_____	_____	_____

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 _____

Physician's signature _____ Date _____