PATIENT HISTORY RECORD

Name: ____ Today's date: __________________

WHAT IS(ARE) THE MAIN OR PRIMARY PROBLEM(S) WITH YOUR EYE(S)? ________________________

____

____

Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?

No ☐ Yes ☐ If YES, please explain:____

Have you ever had any eye surgery? No ☐ Yes ☐If YES, please provide date and surgical procedure:_____

____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS AND HISTORY:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)?

   No ☐ Yes ☐ If YES, please explain:____

   ____

2. Have you ever been diagnosed with, or treated for, HIV, AIDS or Hepatitis?

   No ☐ Yes ☐ If YES, please explain:____

   ____

3. Have you ever had any surgery (other than eye surgery)?

   No ☐ Yes ☐ If YES, please provide date and reason: ______________________________________

   ____

4. Have you ever been hospitalized?

   No ☐ Yes ☐ If YES, please provide date and reason: _____________________________________

   ____

5. Do you take any medications?

   No ☐ Yes ☐ If YES, please indicate medication and dosage: ________________________________

   ____

6. Do you have any drug or food allergies?

   No ☐ Yes ☐ If YES, please explain: ____

____

REVIEW OF SYSTEMS	**No**	**Yes**	**If YES, please explain:**
Do you currently have any of the following problems:			
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	______________________
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	______________________
Cardiovascular (heart/blood vessels) (e.g., chest pain irregular heart beat)	☐	☐	______________________
Respiratory (lungs/breathing) (e.g., shortness of breath, wheezing, coughing)	☐	☐	______________________

(OVER)

REVIEW OF SYSTEMS CONTINUED

	No	Yes	If YES, explain:
Gastrointestinal (stomach/intestines) (e.g., heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	____________________
Genitourinary (genitals/kidneys/bladder) (e.g., pain or discomfort, blood in urine)	☐	☐	____________________
Integument (skin) (e.g., rashes, excessive dryness)	☐	☐	____________________
Musculoskeletal (bones/joints/muscles) (e.g., muscle aches, joint pain, swollen joints)	☐	☐	____________________
Neurologic (e.g., numbness, weakness, headaches, paralysis)	☐	☐	____________________
Endocrine (e.g., feeling hot or cold, thyroid problems, prolonged tiredness)	☐	☐	____________________
Hematopopoietic (blood) (e.g., bruise easily, anemia, swollen glands)	☐	☐	____________________
Psychiatric (e.g., depression, anxiety)	☐	☐	____________________
Do you smoke? If YES, how much? If quit in the past 10 years please make a note	☐	☐	____________________
Drink Alcohol? If YES, how much?	☐	☐	____________________

Current Occupation:

____

FAMILY and SOCIAL HISTORY

Do any medical or eye diseases run in your family? If YES, note relation to you (e.g., mother, father, grandparent, sibling, etc.)

	No	Yes	Relation:
Blindness	☐	☐	____________________
Glaucoma	☐	☐	____________________
Macular Degeneration	☐	☐	____________________
Diabetes	☐	☐	____________________
Arthritis	☐	☐	____________________
High Blood Pressure	☐	☐	____________________
Heart Disease	☐	☐	____________________
Stroke	☐	☐	____________________
Cancer	☐	☐	____________________
Thyroid	☐	☐	____________________
Other __________________________	☐	☐	____________________

____ ______________________________

Physician Signature Date