Patient Health History

rev 043010

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

Name ___________________________ Sex________ D.O.B.____________ Date: _________

Primary Care Physician____

EYE HISTORY

Do you currently wear ☐ Glasses ☐ Contact lenses ☐ Neither

Do you have visual difficulty seeing at a distance? ☐No ☐Yes Reading at near? ☐ 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?

	No	Yes		No	Yes		No	Yes
Glaucoma	☐	☐	Itching	☐	☐	Halos	☐	☐
Macular degeneration	☐	☐	Burning	☐	☐	Light sensitivity	☐	☐
Cataracts	☐	☐	Dryness	☐	☐	Redness	☐	☐
Retinal tear or detachment	☐	☐	Sandy/gritty sensation	☐	☐	Drooping eyelid	☐	☐

Other ______________________________

Medical History

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

Other medical conditions:

____

____

____

Have you ever had any hospitalization or surgery? ☐ No ☐ Yes If yes, please explain______________________

____

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

Medication	Reason	Start Date

Medical History (Continued)

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 (example: chest pain, angina, irregular heart beat)	☐ No	☐ Yes	____________
Respiratory (example: coughing, wheezing, shortness of breath, asthma)	☐ No	☐ Yes	____________
Ear/Nose/Throat (example: sore throat, sinus problem, earache, hearing loss)	☐ No	☐ Yes	____________
Gastrointestinal (example: abdominal pain, heartburn, bowel problems, vomiting)	☐ No	☐ Yes	____________
Urinary (example: pain when urinating, blood in urine)	☐ No	☐ Yes	____________
Hematologic/Lymphatic (example: blood disorders, bruising, cuts heal slowly, enlarged glands)	☐ No	☐ Yes	____________
Endocrine (example: thyroid problems)	☐ No	☐ Yes	____________
Skin Disorder (example: rashes, dry skin)	☐ No	☐ Yes	____________
Musculoskeletal (example: joint pain, stiffness or swelling, muscle pain or weakness)	☐ No	☐ Yes	____________
Neurological (example: numbness, headache, seizures, paralysis)	☐ No	☐ Yes	____________
Psychiatric (example: depression, anxiety, insomnia, confusion)	☐ No	☐ Yes	____________

Do you have:				
	Drug allergies	☐ No	☐ Yes	Please list____________
	Food allergies	☐ No	☐ Yes	Please list____________
	Latex allergies	☐ No	☐ Yes	

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	________	____________	____________
	________	____________	____________
	________	____________	____________

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