Today's Date: _____

AIO
THE EYE SURGEONS
VISIONARY EYE CARE

PATIENT HISTORY FORM

Patient Name: _____ SS #: _____ Date of Birth: _____

Primary Care Physician: _____ Optometrist: _____

Ophthalmologist: _____ Cardiologist: _____ Endocrinologist: _____

Pharmacy 1: _____ Pharmacy Location: _____ Pharmacy Phone # (____) _____

Pharmacy 2: _____ Pharmacy Location: _____ Pharmacy Phone # (____) _____

History of Latex Allergy? □YES □NO Allergic to any Medications and/or foods: □YES □NO (If Yes, Please list below)

_____

List All Prescribed and Over-The-Counter Medications, including Vitamins and Supplements currently taking:

Name of Prescription/Medication	Dosage	Frequency	Taken for What Condition

REVIEW OF SYSTEMS - Do you currently have or have you recently had any of the following?

System		Yes/No	System		Yes/No
Constitutional:	Fever	□ Yes □ No	**Metabolic/**	Intolerant to: □ Cold □ Heat	□ Yes □ No
	Weight: □ Loss □ Gain	□ Yes □ No	**Endocrine:**	Excessive Thirst	□ Yes □ No
Eyes:	Double Vision	□ Yes □ No		Urinating more than usual	□ Yes □ No
	Sensitivity to Light	□ Yes □ No	**Neurological:**	Weakness	□ Yes □ No
	Pain	□ Yes □ No		Headache	□ Yes □ No
	Floaters	□ Yes □ No		Numbness of Extremities	□ Yes □ No
ENT:	Hearing Loss	□ Yes □ No	**Psychiatric:**	Depressed Mood	□ Yes □ No
	Sinus Problems	□ Yes □ No	**Integumentary/Skin:**		
	Sore Throat	□ Yes □ No		Dry Skin	□ Yes □ No
Respiratory:	Asthma	□ Yes □ No		Rash	□ Yes □ No
	Cough	□ Yes □ No	**Musculoskeletal:**	Arthritis	□ Yes □ No
Cardiovascular:	Chest Pressure or Discomfort	□ Yes □ No		Joint Swelling	□ Yes □ No
	Irregular Heartbeat/Palpitations	□ Yes □ No	**Hematologic/Lymphatic:**		
Gastrointestinal:	Diarrhea	□ Yes □ No		Easily: □ Bleeds □ Bruises	□ Yes □ No
	Heartburn	□ Yes □ No		Swollen Lymph Nodes	□ Yes □ No
	Vomiting	□ Yes □ No	**Allergic/Immunologic:**		
Genitourinary:	Kidney Stones	□ Yes □ No	□ Environmental	□ Food □ Seasonal	□ Yes □ No

OVER

OCULAR HISTORY

Do you currently have or have you ever had:				Surgery/Diagnosis Description Including Eye and Date
Cataracts	□ Yes □ No	Cataract Surgery	□ Yes □ No	
Cornea Disease	□ Yes □ No	Corneal Surgery	□ Yes □ No	
Glaucoma	□ Yes □ No	Glaucoma Surgery	□ Yes □ No	
Retinal Disease	□ Yes □ No	Retinal Surgery	□ Yes □ No	
Eye Injury/Trauma	□ Yes □ No	Eye Lid Surgery	□ Yes □ No	
		Muscle Surgery	□ Yes □ No	

MEDICAL HISTORY - Do you now, or have you ever had:

	Yes/No		**Yes/No**
Alzheimer's	□ Yes □ No	Hepatitis	□ Yes □ No
Angina	□ Yes □ No	High Blood Pressure	□ Yes □ No
Asthma	□ Yes □ No	High Cholesterol	□ Yes □ No
Auto-immune Disorder	□ Yes □ No	HIV/AIDS	□ Yes □ No
Cancer	□ Yes □ No	Kidney Disease	□ Yes □ No
COPD	□ Yes □ No	Liver Disease	□ Yes □ No
Dementia	□ Yes □ No	Parkinson's	□ Yes □ No
Diabetes : Type 1 □ Type 2 □	□ Yes □ No	Seizures/Tremors	□ Yes □ No
Emphysema	□ Yes □ No	Stroke	□ Yes □ No
Heart Attack	□ Yes □ No	Thyroid Disease	□ Yes □ No
Heart Disease	□ Yes □ No	* Peds Pt - Born Prematurely	□ Yes □ No
Other/Previous Surgery:			

FAMILY HISTORY

□ Yes □ No	Amblyopia/Lazy Eye	□ Yes □ No	Diabetes
□ Yes □ No	Blindness	□ Yes □ No	Glaucoma
□ Yes □ No	Cardiovascular/Heart Disease	□ Yes □ No	Macular Degeneration
□ Yes □ No	Cataracts	□ Yes □ No	Retinal Disease

SOCIAL HISTORY

Have you ever used tobacco?	□ No/Never □ Yes	Type of Tobacco:	Amount:
Have you ever tried to quit using tobacco?	□ No/Never □ Yes		
Do you drink alcohol?	□ No □ Yes	How often:	

Do you have any special needs?

□ Wheelchair: Are you able to transfer on your own to an exam chair □ Yes □ No
□ Walker
□ Oxygen
□ Hearing Aids
□ Other: _____

In case of an emergency, whom shall we contact?
Name: _____ Relationship: _____ Phone: _____

Patient's Signature: _____ Date: _____

Reviewed/Updated Date: _____ Interval Changes □ Yes □ No MD Signature: _____