PATIENT HISTORY FORM

Patient Name: ______________________ SS #: ____________ Date of Birth: __________

Home Phone: ____________ Cell Phone: ____________ Email: ______________________

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?

Constitutional:
- Fever ❑ YES ❑ NO
- Weight: ❑ Loss ❑ Gain ❑ YES ❑ NO

Eyes:
- Double Vision ❑ YES ❑ NO
- Sensitivity to Light ❑ YES ❑ NO
- Pain ❑ YES ❑ NO
- Floaters ❑ YES ❑ NO

ENT:
- Hearing Loss ❑ YES ❑ NO
- Sinus Problems ❑ YES ❑ NO
- Sore Throat ❑ YES ❑ NO

Respiratory:
- Asthma ❑ YES ❑ NO
- Cough ❑ YES ❑ NO

Cardiovascular:
- Chest Pressure or Discomfort ❑ YES ❑ NO
- Irregular Heartbeat/Palpitations ❑ YES ❑ NO

Gastrointestinal:
- Diarrhea ❑ YES ❑ NO
- Heartburn ❑ YES ❑ NO
- Vomiting ❑ YES ❑ NO

Genitourinary:
- Kidney Stones ❑ YES ❑ NO

Metabolic:
- Intolerant to: ❑ Cold ❑ Heat ❑ YES ❑ NO

Endocrine:
- Excessive Thirst ❑ YES ❑ NO
- Urinating more than usual ❑ YES ❑ NO

Neurological:
- Weakness ❑ YES ❑ NO
- Headache ❑ YES ❑ NO
- Numbness of Extremities ❑ YES ❑ NO

Psychiatric:
- Depressed Mood ❑ YES ❑ NO

Integumentary/Skin:
- Dry Skin ❑ YES ❑ NO
- Rash ❑ YES ❑ NO

Musculoskeletal:
- Arthritis ❑ YES ❑ NO
- Joint Swelling ❑ YES ❑ NO

Hematologic/Lymphatic:
- Easily: ❑ Bleeds ❑ Bruises ❑ YES ❑ NO
- Swollen Lymph Nodes ❑ YES ❑ NO

Allergic/Immunologic:
- ❑ Environmental ❑ Food ❑ Seasonal ❑ YES ❑ NO

PLEASE TURN OVER

OCULAR HISTORY

Do you currently have or have you ever had:

Cataracts ❑ YES ❑ NO
Cornea Disease ❑ YES ❑ NO
Glaucoma ❑ YES ❑ NO
Retinal Disease ❑ YES ❑ NO
Eye Injury/Trauma ❑ YES ❑ NO

Cataract Surgery ❑ YES ❑ NO
Corneal Surgery ❑ YES ❑ NO
Glaucoma Surgery ❑ YES ❑ NO
Retinal Surgery ❑ YES ❑ NO
Eye Lid Surgery ❑ YES ❑ NO

Surgery/Diagnosis Description Including Eye and Date:

____
____
____
____
____
____

MEDICAL HISTORY

Do you now, or have you ever had:

Alzheimer's ❑ YES ❑ NO
Angina ❑ YES ❑ NO
Asthma ❑ YES ❑ NO
Auto-immune Disorder ❑ YES ❑ NO
Cancer ❑ YES ❑ NO
COPD ❑ YES ❑ NO
Dementia ❑ YES ❑ NO
Diabetes: Type 1 ❑ Type 2 ❑ ❑ YES ❑ NO
Emphysema ❑ YES ❑ NO
Heart Attack ❑ YES ❑ NO
Heart Disease ❑ YES ❑ NO
Hepatitis ❑ YES ❑ NO

High Blood Pressure ❑ YES ❑ NO
High Cholesterol ❑ YES ❑ NO
HIV/AIDS ❑ YES ❑ NO
Kidney Disease ❑ YES ❑ NO
Liver Disease ❑ YES ❑ NO
Parkinson's ❑ YES ❑ NO
Seizures/Tremors ❑ YES ❑ NO
Stroke ❑ YES ❑ NO
Thyroid Disease ❑ YES ❑ NO

Other: ______________________________

Previous Surgery:

____
____

FAMILY HISTORY

Amblyopia/Lazy Eye ❑ YES ❑ NO
Blindness ❑ YES ❑ NO
Cardiovascular/Heart Disease ❑ YES ❑ NO
Cataracts ❑ YES ❑ NO

Diabetes ❑ YES ❑ NO
Glaucoma ❑ YES ❑ NO
Macular Degeneration ❑ YES ❑ NO
Retinal Disease ❑ YES ❑ NO

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: ______________________________

PLEASE TURN OVER