PATIENT HISTORY RECORD

DATE (MM/DD/YY) REFERRED BY BIRTH DATE

PATIENT NAME SEX AGE

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.)
   Yes ____ No ____ If YES, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or 'lazy' eye, retinal detachment)?
   Yes ____ No ____ If YES, please explain: _____
3. Have you ever had any surgery:
   Yes ____ No ____ If Yes, please provide date and reason _____
4. Have you ever been hospitalized?
   Yes ____ No ____ If YES, please provide date and reason _____
5. Do you take any medications?
   Yes ____ No ____ If YES, please list: _____
   Do you take any eye medications?
   Yes ____ No ____ if YES, please list: _____
6. Do you have any drug or food allergies?
   Yes ____ No ____ If YES, please list: _____

Review of Systems **Please circle Yes / No** **If Yes, please explain:**

Do you currently have any of the following problems:

Chronic fever, unexpected weight loss/gain, fatigue Y or N _____

Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat) Y or N

Heart problems (e.g., chest pain, irregular heart beat) Y or N _____

Respiratory problems (e.g., shortness of breath, wheezing, coughing) Y or N

Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting) Y or N

Urinary problems (e.g. pain or discomfort, blood in urine) Y or N _____

Skin problems (e.g., rashes, excessive dryness) Y or N _____

Musculloskeletal problems (e.g., muscle aches, joint pain, swollen joints) Y or N

Neurologic problems (e.g., numbness, weakness, headaches, paralysis) Y or N

Psychiatric problems (e.g., depression, anxiety) Y or N _____

Family and Social History:

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer glaucoma, macular generation) Yes ____ No ____ If YES, please explain: _____

Do you smoke? If yes, how much _____ Drink alcohol? If yes, how much _____

If employed, how many hours per week do you work? _____

Comments

M.D. Signature Date