

PATIENT HEALTH HISTORY

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

Date _____ Acct # _____

Patient Name _____ Sex _____ Birth date _____

Soc Sec # _____ Primary Care Physician _____

Address _____

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____ Hours/week _____

EYE HISTORY

Do you currently wear Glasses Contact Lenses Neither

Do you have visual difficulty when reading? No Yes

Do you have visual difficulty when driving? 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?

	<small>Check here if you are currently experiencing this condition</small>				<small>Check here if you are currently experiencing this condition</small>		
Glaucoma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Halos	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Light sensitivity	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Cataracts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Redness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Retinal tear or detachment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Itching	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Lazy eye/wandering eye	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Burning	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Eye pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Dryness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Sandy/gritty sensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Decreased vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Foreign body sensation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Double vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Discharge	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Flashes of light in eye(s)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Crusting on eyelid	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>
Floating dark spots in eye(s)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>	Drooping eyelid	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/>

Other _____

MEDICAL HISTORY

Are you currently being treated for any of the following?

High Blood Pressure Diabetes Heart disease Stroke Arthritis Other _____ No Yes

Have you ever been treated for a serious illness or medical condition? No Yes

If yes, please explain _____

Have you had any hospitalization or surgery? No Yes

If yes, please explain _____

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

Do you have:

Drug allergies No Yes Please list _____

Food allergies No Yes Please list _____

Latex allergies No Yes _____

MEDICAL HISTORY (Cont.)

Review of systems:

Are you currently experiencing problems with any of the following?

If yes, please explain

Sudden weight gain or loss	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Chronic fever or chronic fatigue	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart (example: chest pain, angina, irregular heart beat)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Respiratory (example: coughing, wheezing, shortness of breath, asthma)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Ear/Nose/Throat (example: sore throat, sinus problem, earache, hearing loss)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Gastrointestinal (example: abdominal pain, heartburn, bowel problems, vomiting)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Urinary (example: pain when urinating, blood in urine)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Hematologic/Lymphatic (example: blood disorders, bruising, cuts heal slowly, enlarged glands)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Endocrine (example: thyroid problems)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Integumentary (example: rashes, dry skin)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Musculoskeletal (example: joint pain, stiffness or swelling, muscle pain or weakness)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Neurological (example: numbness, headache, seizures, paralysis)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Psychiatric (example: depression, anxiety, insomnia, confusion)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Allergic/Immunologic (example: reaction to food or drugs, allergies, hay fever)	<input type="checkbox"/> No <input type="checkbox"/> 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	_____	_____	_____
Children	_____	_____	_____
Spouse	_____	_____	_____

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

Physician's signature Date