PATIENT HISTORY FORM

NAME: **DATE:**

Date of Birth: ____________________________ Date of **Last Eye Exam**:____________________

List any **medications** you currently take (prescription and over-the-counter): ____________
____

Do you have **allergies** to any medications? _______ If yes, which ones? __________________
____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc) or injuries: ____
____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy): _____________
____

Do you **currently** have any problems in the following areas?

	Yes	No	**If yes, please explain**
EYES			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty or foreign body sensation			
Itching			
Burning			
Flashes or floaters			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (hearing loss, sinus problems, sore throat, etc)			
CARDIOVASCULAR (high BP, heart problems, irregular heart beat, etc)			
RESPIRATORY (asthma, shortness of breath, wheezing, coughing, etc)			
GASTROINTESTINAL (ulcer, heartburn, vomiting, diarrhea, hepatitis, etc)			
GENITAL, KIDNEY, BLADDER (urinary problems, impotence, STDs, etc)			

continued on reverse

PATIENT HISTORY FORM (continued)

	Yes	No	**If yes, please explain**
MUSCLES, BONES, JOINTS (joint pain, muscle aches, swollen joints, etc)			
SKIN (skin rashes, excessive dryness, eczema, growths, etc)			
NEUROLOGICAL (numbness, headache, stroke, multiple sclerosis, etc)			
PSYCHIATRIC (anxiety, depression, insomnia, psychosis, etc)			
ENDOCRINE (diabetes, thyroid, etc)			
BLOOD/LYMPH (blood clotting disorders, leukemia, anemia, etc)			
ALLERGIC/IMMUNOLOGIC (hay fever, seasonal allergies, itching, hives, HIV, etc)			
FEMALES Are you pregnant? Nursing?			

FAMILY HISTORY

	Yes	No	Relationship to Patient
Blindness			
Glaucoma			
Macular degeneration			
Retinal detachment			
Retinitis pigmentosa			
Multiple sclerosis			
Rheumatoid arthritis			
Cancer			
Diabetes			
Heart disease			
High blood pressure			
Kidney disease			
Lupus			
Sickle cell			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc)? Y N
If yes, please explain: ______________________________

Have you ever worn contact lenses? Y N
Do you currently wear contact lenses? Y N For how long now? ______________
Do you wear glasses? Y N For how long now? ______________
Do you smoke? Y N If yes, how much? ______________
Do you drink alcohol? Y N If yes, how much? ______________
Do you use any illegal drugs? Y N If yes, which ones? ______________
Have you ever used illegal IV drugs? Y N
Have you ever had a blood transfusion? Y N

Physician's signature ______________________________ Date ______________