PATIENT HISTORY RECORD

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

▲ PATIENT'S NAME ▲ SEX ▲ AGE

▲ ADDRESS ▲ PHONE (H)

▲ EMPLOYER ▲ OCCUPATION ▲ PHONE (W)

▲ SOC. SEC. NO. ▲ PRIMARY CARE PHYSICIAN

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: ______
6. Do you take any eye medications?
   ☐ Yes ☐ No If YES, please list: ______
7. Do you have any drug or food allergies?
   ☐ Yes ☐ No If YES, please list: ______

Review of Systems

Do you currently have any of the following problems:

	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g., chest pain, irregular heartbeat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g., rashes, excessive dryness)	☐	☐	
Musculoskeletal probems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	

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

If employed, how many hours a week do you work? ______

Does your employment contribute to any stress in your life? ☐ Yes ☐ No

▲ Comments

▲ M.D. Signature ▲ Date

(over)

Do you currently have any problems in the following areas? If "YES," please provide information.

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double Vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			

SOCIAL HISTORY

Current occupation: ____________________

Marital Status (married, divorced, single, widowed): ____________________

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Have you ever tried to wear contact lenses? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

IF YES, how long have you worn contact lenses? ____________________

Do you currently wear glasses? ☐ YES ☐ NO

If YES, how long have you had the current prescription? ____________________

Do you drink alcohol? ☐ YES ☐ NO IF YES: occasional 1 per day 2-3 per day 4+ per day

Do you smoke? ☐ YES ☐ NO IF YES: occasional ½ pack/day 1 pack/day 1+ pack/day

Have you ever had a blood transfusion? ☐ YES ☐ NO

History reviewed: ☐ No Changes. ☐ Additions as noted above.

Physician's Signature: ____________________ Date: ____________________