PATIENT HISTORY FORM

DATE _______________ **PATIENT'S NAME** ____

SEX: M F **AGE**: ____________________**OCCUPATION**:____________________ **BIRTH DATE**___________________

PRIMARY CARE PHYSICIAN____

EYE HISTORY:

Do you wear glasses? ______________________ Do you wear contacts? ______________________

When was your last exam? ________________________ Have you been seen in this clinic before? ______________

*__Have you ever been diagnosed with cataracts, glaucoma, macular degeneration, lazy eye or other eye condition?__

YES ❒ NO ❒ If YES, please explain: ____

*Have you ever had any **eye injury or surgery?** YES ❒ NO ❒ If YES, please explain: ______________________________

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*List any **eye medications** (drops or pills) you are taking**:** ____

*List any other surgeries you have had: ____

*List any other medications you are taking: ____

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*What do you take medications for? ____

*List any drug allergies you have **and** your reaction: ____

REVIEW OF SYSTEMS

*Do you **currently** have any of the following problems?	YES	NO	If YES, please explain:
Neurological problems (e.g., numbness, headaches, paralysis)	❒	❒	____________________
Psychiatric problems (e.g., depression, anxiety)	❒	❒	____________________
Heart problems	❒	❒	____________________
Respiratory problems (e.g., wheezing, coughing,)	❒	❒	____________________
Chronic fever, unexpected weight loss/gain, fatigue	❒	❒	____________________
Ear/nose/throat problems (e.g., hearing loss, sinus, sore throat)	❒	❒	____________________
Gastrointestinal problems (e.g., diarrhea, vomiting, heartburn)	❒	❒	____________________
Urinary problems	❒	❒	____________________
Skin problems	❒	❒	____________________
Musculoskeletal problems (e.g., muscle aches, joint pain)	❒	❒	____________________

FAMILY AND SOCIAL HISTORY

*Do any medical or eye problems **run in your family** (e.g., diabetes, high blood pressure, cataracts, glaucoma, thyroid, lazy eye, macular degeneration, etc.)? YES ❒ NO ❒ If YES, please explain: ____

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Do you smoke: ______ Do you drink alcohol? ______

Doctor's Signature: ____ Date: ____