Patient History Form

Today's Date _____

Patient Name _____ Patient Date of Birth _____

Medical History

Are you allergic to any medications? ❒ No ❒ Yes (describe) _____

Please list any current medications (with dosage) you are taking (including over-the-counter eye drops, vitamins or supplements, aspirin and oral contraceptives).

_____

_____

List any major injuries, surgeries and/or hospitalizations you have had and date(s). _____

_____

Have you had any of the following:

❒ Crossed eyes ❒ Lazy eye ❒ Drooping eyelid ❒ Eye infection
❒ Eye injury ❒ Eye Surgery ❒ Glaucoma ❒ Cataracts ❒ Macular degeneration

Do you or have you ever experienced any problems in the following areas?

System Constitutional	**No**	**Yes**	**Endocrine**	**No**	**Yes**	**Gastrointestinal**	**No**	**Yes**
Fever/Weight loss/Gain	N	Y	Non-insulin Dependent Diabetes	N	Y	Crohn's	N	Y
			Insulin Dependent Diabetes	N	Y	Colitis	N	Y
Integumentary			Thyroid Dysfunction	N	Y	Ulcer	N	Y
Eczema	N	Y	Hormonal Dysfunction	N	Y	Digestive	N	Y
Psoriasis	N	Y						
Cancer	N	Y	**Respiratory**			**Genitourinary**		
			Asthma	N	Y	Genitals/Kidney/Bladder	N	Y
Neurological			Chronic Bronchitis	N	Y			
Headaches	N	Y	Emphysema	N	Y	**Allergy/Immunological**		
Migraines	N	Y	Cancer	N	Y	Drug Allergy	N	Y
Seizures	N	Y				Environmental Allergy	N	Y
Multiple Sclerosis	N	Y	**Vascular/Cardiovascular**			Rheumatoid Arthritis	N	Y
Cancer	N	Y	High Blood Pressure	N	Y	Lupus	N	Y
			High Cholesterol	N	Y			
Ear/Nose/Throat			Stroke	N	Y	**Psychiatric**		
Allergies/Hay Fever	N	Y	Heart Disease	N	Y	Depression	N	Y
Sinus Congestion	N	Y				Panic Disorder	N	Y
Chronic Cough	N	Y	**Lymphatic/Hematological**			Schizophrenia	N	Y
Dry Throat/Mouth	N	Y	Bleeding Problems	N	Y			
						Pregnant/Nursing	N	Y

Your Eye Symptoms – Do you (patient) experience any of the following?

Blurred Vision	N	Y	Flashing Lights	N	Y	Seeing Rings Around Lights	N	Y
Distorted Vision	N	Y	Painful Eyes	N	Y	Color Vision Difficulties	N	Y
Double Vision	N	Y	Gritty/Sandy Eyes	N	Y	Depth Perception Problem	N	Y
Red Eyes	N	Y	Aching Eyes	N	Y	Losing Place While Reading	N	Y
Watery Eyes	N	Y	Drawing/Pulling	N	Y	Nigh Vision Problems	N	Y
Itchy Eyes	N	Y	Dizziness	N	Y	Extreme Light Sensitivity	N	Y
Burning Eyes	N	Y	Excessive Squinting	N	Y	Discharge From Eyes	N	Y
Dry Eyes	N	Y	Other _____			Floating Spots	N	Y

Family History – Has anyone in the patient's family (blood relative) had any of the following?

Cataracts	N	Y	Glaucoma	N	Y	Heart Disease	N	Y
Cornea Disease	N	Y	Lazy Eye	N	Y	Diabetes	N	Y
Crossed Eyes	N	Y	Macular Degeneration	N	Y	High Blood Pressure	N	Y
Retina Disease	N	Y	Cancer	N	Y	Other _____		

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.*

❒ Yes, I would prefer to discuss my Social History Information directly with the doctor.

Occupation: _____

Do you drive? N Y If yes, do you have visual difficulty while driving? _____

If yes, please describe: _____

Do you use tobacco? N Y If yes, type/amount/how long? _____

Do you drink alcohol? N Y If yes, type/amount/how long? _____

Hobbies/Recreation/Sport – Please mark the boxes that apply to you.

❒ Boating/fishing ❒ Gardening ❒ Photography ❒ Sewing ❒ Card playing ❒ Golf ❒ Racquetball/Handball ❒ Flying ❒ Swimming/Scuba ❒ Crafts ❒ Hunting ❒ Skiing ❒ Music

Do you wear: ❒ glasses ❒ contact lenses

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ No ❒ Yes

How often do you replace your contact lenses? ❒ Daily ❒ 1-2 Weeks ❒ Monthly ❒Quarterly ❒ Yearly ❒ Other _____

What brand of contact lenses do you wear? _____

Please provide any additional information you would like to add:

_____

The information provided is true and complete to the best of my knowledge.

Patient Signature (or Guardian if patient is a minor)	Date
Name of Person Completing Form (if not patient)	Relationship to Patient