

# 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
<b>EYES</b>			
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 feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Infection of eye or lid			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
<b>GENERAL/CONSITUTIONAL</b> (fever, weight loss, other)			
<b>EARS, NOSE, THROAT</b> (hearing loss, sinus problems, sore throat, etc)			
<b>CARDIOVASCULAR</b> (high BP, heart problems, irregular heart beat, etc)			
<b>RESPIRATORY</b> (asthma, shortness of breath, wheezing, coughing, etc)			
<b>GASTROINTESTINAL</b> (stomach ulcer, heartburn, vomiting, diarrhea, hepatitis, etc)			
<b>GENITAL, KIDNEY, BLADDER</b> (urinary problems, impotence, STDs, etc)			

*Continued on back...*

**Patient Initials** \_\_\_\_\_

## PATIENT HISTORY FORM (continued)

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

### FAMILY HISTORY

	Yes	No	Relationship to Patient
Blindness			
Glaucoma			
Macular degeneration			
Arthritis			
Cancer			
Diabetes			
Heart disease or 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 currently wear glasses? Y N For how long now? \_\_\_\_\_  
 Have you ever had a blood transfusion? Y N  
 Have you ever used any illegal drugs? Y N If yes, which ones? \_\_\_\_\_  
 Do you drink alcohol? Y N If yes, how much? \_\_\_\_\_  
 Do you smoke? Y N If yes, how much? \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient Initials** \_\_\_\_\_