

PATIENT HISTORY RECORD

DATE (MM/DD/YY) _____

BIRTH DATE (MM/DD/YY) _____

PATIENT'S NAME

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: _____
 Do you take any eye medications?
 Yes No If YES, please list: _____

6. 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 heart beat).....			_____
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 problems (e.g., muscle aches, joint pain, swollen joints).....			_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis).....			_____
Psychiatric problems (e.g., depression, anxiety).....			_____

FAMILY AND SOCIAL HISTORY

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

Do you smoke? If yes, how much? _____ Drink alcohol? If yes, how much? _____

If employed, how many hours per week do you work? _____

Comments _____

Physician's Signature _____

Date _____