PATIENT HISTORY RECORD

Name:_____ Today's date:_____

WHAT IS (ARE) THE MAIN OR PRIMARY PROBLEM(S) WITH YOUR EYE(S)?_____

_____

_____

Have you ever had any eye disease (e.g./ glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?

No ☐ Yes ☐ If YES, please explain: _____

_____

Have you ever had any eye surgery? No ☐ Yes ☐ If YES, please provide date and surgical procedure:___

_____

_____

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.)?

No ☐ Yes ☐ If YES, please explain: _____

_____

2. Have you ever had any surgery (other than eye surgery)?

No ☐ Yes ☐ If YES, please provide date and reason: _____

_____

3. Have you ever been hospitalized?

No ☐ Yes ☐ If YES, please provide date and reason: _____

_____

4. Do you take any medications?

No ☐ Yes ☐ If YES, please indicate medication and dosage: _____

_____

5. Do you have any drug or food allergies?

No ☐ Yes ☐ If YES, please explain: _____

REVIEW OF SYSTEMS	No	Yes	If YES, please explain:
Do you currently have any of the following problems:			
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	_____
Cardiovascular (heart/blood vessels) (e.g., chest pain, irregular heart beat)	☐	☐	_____
Respiratory (lungs/breathing) (e.g., shortness of breath, wheezing, coughing)	☐	☐	_____

REVIEW OF SYSTEMS CONTINUED

	No	Yes	If YES, please explain:
Gastrointestinal (stomach/intestines) (e.g., heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Genitourinary (genitals/kidneys/bladder) (e.g., pain or discomfort, blood in urine)	☐	☐	_____
Integument (skin) (e.g., rashes, excessive dryness)	☐	☐	_____
Musculoskeletal (bones/joints/muscles) (e.g., muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurologic (e.g., numbness, weakness, headaches, paralysis)	☐	☐	_____
Endocrine (e.g., feeling hot or cold, thyroid problems, Prolonged tiredness)	☐	☐	_____
Hematopopoietic (blood) (e.g., bruise easily, anemia, swollen glands)	☐	☐	_____
Psychiatric (e.g., depression, anxiety)	☐	☐	_____

FAMILY and SOCIAL HISTORY

Do any medical or eye diseases run in your family?
(e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

No ☐ Yes ☐ If YES, please explain: _____

_____

Do you smoke? If YES, how much? _____

Drink alcohol? If YES, how much? _____

Current occupation or previous profession: _____

_____

_____

Physician Comments

_____

M.D. Signature Date

Updated Information:

_____

_____

_____