

PATIENT HISTORY

Date _____ Referred By _____ Primary Care Physician _____

Patient's Name _____ Sex _____ Date of Birth _____ Age _____

Eye Surgeries:

Right Eye

Left Eye

Yes **No**

Date **Doctor**

Date **Doctor**

___ ___ Cataract
 ___ ___ Laser
 ___ ___ Retina
 ___ ___ Other

Are you being treated for Glaucoma? ___ Yes ___ No If "Yes" year diagnosed _____

List any other eye problems _____

PLEASE GIVE THE FOLLOWING MEDICAL/SURGICAL INFORMATION:

<u>Medical:</u>	<u>Yes</u>	<u>No</u>	<u>Year Diagnosed</u>	<u>Surgical:</u>	<u>Yes</u>	<u>No</u>	<u>Date of Surgery</u>
Diabetes	___	___	_____	Appendectomy	___	___	_____
Heart Problems	___	___	_____	Hysterectomy	___	___	_____
High Blood Pressure	___	___	_____	Gallbladder	___	___	_____
Stroke	___	___	_____	Heart	___	___	_____
TB	___	___	_____	Other _____	___	___	_____
Hepatitis	___	___	_____				
Asthma/Emphysema	___	___	_____				
Other _____							

List Medications

Check here if none

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

List Allergies

Check here if no allergies

1. _____
2. _____
3. _____
4. _____
5. _____

Please See Back of Sheet

(For office use only. Do NOT write below this line)

Reviewed by _____ Date _____ No Changes ___ Updated _____

Reviewed by _____ Date _____ No Changes ___ Updated _____

Reviewed by _____ Date _____ No Changes ___ Updated _____

FAMILY AND SOCIAL HISTORY: Does anyone in your immediate family have the following?

Do any medical diseases run in your family? (e.g. diabetes, high blood pressure, cancer) Yes ___ No ___
If yes, explain _____

Do any eye diseases run in your family? (e.g. glaucoma, macular degeneration, retinitis pigmentosa) Yes ___ No ___

Are you married? Yes ___ No ___ Widowed ___ Number of Children ___

Do you use tobacco products? Yes ___ No ___ What and how much? _____

Do you habitually use any other drugs (such as alcohol)? Yes ___ No ___

Does anyone help you with transportation or medical care? Yes ___ No ___

REVIEW OF SYSTEMS: Do you have any of the following problems: If “yes” explain

1. Fever, weight loss/gain, fatigue Yes ___ No ___
2. Ear/Nose/Throat problems (e.g. shortness of breath, sinus problems, sore throat) Yes ___ No ___
3. Heart problems (e.g. chest pain, irregular heart beat) Yes ___ No ___
4. Respiratory problems (e.g. shortness of breath, wheezing, coughing) Yes ___ No ___
5. Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting) Yes ___ No ___
6. Urinary problems (e.g. pain or discomfort, blood in urine) Yes ___ No ___
7. Skin problems (e.g. rashes, excessive dryness) Yes ___ No ___
8. Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints) Yes ___ No ___
9. Neurological problems (e.g. numbness, weakness, headaches, paralysis) Yes ___ No ___
10. Psychiatric problems (e.g. depression, anxiety) Yes ___ No ___
11. Endocrine (e.g. diabetes, hypothyroid) Yes ___ No ___
12. Blood/Lymph (e.g. anemia, blood disorders) Yes ___ No ___
13. Allergic/Immunologic (e.g. lupus, asthma) Yes ___ No ___

Have you ever had problems from general anesthesia? Yes _____ No _____ If “yes”, explain _____

Are you taking any blood thinners or aspirin products? Yes _____ No _____ If “yes”, explain _____

Are you taking any herbal products? Yes _____ No _____ If “yes”, explain _____

Does your Doctor have you on any special diet? Yes _____ No _____ If “yes”, explain _____