PATIENT HISTORY FORM

Name:_____ D.O.B.:_____ Date:_____

Address:_____ Email:_____ Zip:_____

Home Phone:_____ Work or Cell Phone:_____

Occupation:_____ Insurance: Vision_____ Health_____

VISUAL AND MEDICAL HISTORY

Date of last eye exam:_____ By Whom:_____

Reason for today's exam:_____

Who is your family doctor?_____ Date of last exam:_____

Medications you are currently taking:_____

Medications you are **allergic** to:_____

Please list any major surgeries, injuries, or hospitalizations:_____

Do you wear contact lenses? Y N If yes, type worn?_____

Are you interested in laser or surgical vision correction? Y N

FAMILY HISTORY

Please check any conditions that apply to yourself or your immediate family members: (Circle S for self or F for family)

Diabetes: S F Blindness: S F Glaucoma: S F Macular Degeneration: S F

Retinal Disease or Detachment: S F Cancer: S F Heart Disease: S F

Hypertension: S F Thyroid Disease: S F Other:_____

SOCIAL HISTORY

Do you drive? Y N Do you use tobacco products? Y N Do you use illegal drugs? Y N

Have you been exposed or infected with the following: HIV? Y N Hepatitis? Y N

Syphilis? Y N Gonorrhea? Y N

REVIEW OF SYSTEMS

Do you currently have, or have you had, any of the following problems?

	Yes	No
Eyes		
Loss of vision	___	___
Blurred vision	___	___
Distorted vision	___	___
Double vision	___	___
Loss of side vision	___	___
Dryness or burning	___	___
Redness	___	___
Itching	___	___
Glare / light sensitivity	___	___
Excess tearing / watering	___	___
Eye pain or irritation	___	___
Styes or cysts	___	___
Chronic infections	___	___
Flashes or floaters	___	___
Ears, Nose, Mouth, Throat		
Allergies	___	___
Sinus congestion	___	___
Runny nose	___	___
Chronic cough	___	___
Dry mouth / throat	___	___

	Yes	No
Respiratory	___	___
Asthma	___	___
Chronic bronchitis	___	___
Emphysema	___	___
Vascular / Cardiovascular		
Diabetes	___	___
Heart problems	___	___
High blood pressure	___	___
Vascular disease	___	___
Gastrointestinal		
Diarrhea or constipation	___	___
Genitourinary		
Genitals / kidney / bladder	___	___
Bones / Joints / Muscles		
Muscle pain	___	___
Joint pain	___	___
Rheumatoid arthritis	___	___
Lymphatic / Hematologic		
Anemia	___	___
Bleeding problems	___	___

	Yes	No
Allergic / Immunologic	___	___
Psychiatric	___	___
Endocrine		
Thyroid	___	___
Constitutional	___	___
Fever, weight	___	___
Loss / gain	___	___
Integumentary (skin)	___	___
Neurological		
Headaches	___	___
Migraines	___	___
Seizures	___	___