

PATIENT HISTORY RECORD

Patient's Name: _____

Date: _____

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

	Yes	No	If YES, please explain:
Do you currently have any of the follow problems:			
Chronic fever, unexpected weight loss/gain, fatigue -----	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat) -----	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat) -----	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing) -----	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting) -----	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (e.g. pain or discomfort, blood in urine) -----	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, excessive dryness) -----	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints) -----	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis) -----	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g., depression, anxiety) -----	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family and Social History

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

Yes No If YES, please explain: _____

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

Other medical information: