# PATIENT HISTORY FORM

Patient Name ______________________________ Date ______________________

Birth Date __________________ Race: ________ Referred by________________________

| OCULAR COMPLAINTS<br>(i.e. red/irritated eyes, flashes, floaters, pain, cataracts, eyelid problems, glare, tearing/dry eyes etc..) | | |
|---|---|---|
| | ☐ Yes ☐ No | |
| If YES, Please list all OCULAR PROBLEMS you wish to discuss with your doctor today: | | |
| | | |

| PAST OCULAR PROCEDURES:<br>Have you been diagnosed with ANY ocular Surgeries or Procedures?<br>(i.e. Cataract Surgery, Glaucoma Surgery, Laser Surgeries, LASIK, Retinal Surgeries, etc.) | | |
|---|---|---|
| | ☐ Yes ☐ No | |
| If YES, Please list all previous OCULAR PROCEDURES: | | |
| | | |

| SYSTEMIC ILLNESSES:<br>Have you had any systemic illnesses?<br>(i.e. Thyroid Problems, Diabetes, Hypertension, Heart Disease, Cancer, etc.) | | |
|---|---|---|
| | ☐ Yes ☐ No | |
| If YES, Please list all PAST MEDICAL ILLNESSES: | | |
| | | |

| PAST OCULAR HISTORY/ TRAUMA:<br>Have you been diagnosed with ANY ocular problems/any past Head or Ocular Trauma?<br>(i.e. Cataracts, Glaucoma, Macular Degeneration, Falls, Concussions, Motor Vehicle Accidents, etc.) | | |
|---|---|---|
| | ☐ Yes ☐ No | |
| If YES, Please list all PAST HEAD/OCULAR TRAUMA: | | |
| If YES, Please list all OCULAR HISTORY | | |

| PAST BODILY SURGERIES:<br>Have you had ANY general/bodily Surgeries or Procedures?<br>Please List ALL Past Surgeries | | |
|---|---|---|
| | ☐ Yes ☐ No | |
| If YES, Please list all previous GENERAL SURGERIES: | | |
| | | |

**PLEASE TURN OVER – CONTINUED...**

## FAMILY AND SOCIAL HISTORY:
**Does any of your family have any Medical or Eye Diseases?**
**If YES, please note relationship to patient**

☐ Yes ☐ No

| | | | | |
|---|---|---|---|---|
| Glaucoma | | | | |
| Diabetes | | Do you smoke? If YES, how much? | Yes | No |
| High blood pressure | | How much: | | |
| Macular degeneration | | Drink alcohol? If YES, how much? | Yes | No |
| *Other* | | How much: | | |

Comments: ___

## REVIEW OF SYSTEMS
**Do you currently have any of the following problems?**

| | | If YES, please explain. |
|---|---|---|
| 1. Do you have any allergies to any medication? | ☐ Yes ☐ No | |
| 2. **Constitutional** (fever, weight loss, other) | ☐ Yes ☐ No | |
| 3. **Eyes** (glaucoma, cataract, lazy eye, retina problems, other - please specify) | ☐ Yes ☐ No | |
| 4. **Ear / nose / mouth / throat** (hearing loss, sinus problems, sore throat) | ☐ Yes ☐ No | |
| 5. **Cardiovascular** (heart problems, chest pain, irregular heart beat) | ☐ Yes ☐ No | |
| 6. **Respiratory** (asthma, shortness of breath, wheezing, coughing) | ☐ Yes ☐ No | |
| 7. **Gastrointestinal** (heartburn, abd. pain, diarrhea, vomiting) | ☐ Yes ☐ No | |
| 8. **Genitourinary** (urinary problems, blood in urine) | ☐ Yes ☐ No | |
| 9. **Integumentary** (skin rashes, excessive dryness) | ☐ Yes ☐ No | |
| 10. **Musculoskeletal** (muscle aches, joint pain, swollen joints) | ☐ Yes ☐ No | |
| 11. **Neurological** (numbness, weakness, headaches, paralysis) | ☐ Yes ☐ No | |
| 12. **Hematologic/Lymphatic** (blood disorders, leukemia) | ☐ Yes ☐ No | |
| 13. **Allergic/Immunologic** (hay fever, allergies) | ☐ Yes ☐ No | |
| 14. **Endocrine** (thyroid problems) | ☐ Yes ☐ No | |
| 15. **Psychiatric** (depression, anxiety) | ☐ Yes ☐ No | |

## CURRENT MEDICATIONS:
**Does you take ANY current Medications or Vitamins/Supplements?**
**If YES, Please List All with Included Milligrams if known:**

☐ Yes ☐ No

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