



PATIENT HISTORY

Date _____

Name _____

Birthdate _____

Primary Care Physician _____

Did anyone refer you to our office? _____

MEDICAL HISTORY

Current or past eye conditions, eye injuries, laser treatments, and eye surgeries (e.g. "lazy" eye)

Current or past medical conditions (e.g. diabetes, high blood pressure, heart, asthma, arthritis, thyroid)

Any other surgeries with dates (If you have had surgery, any problems with anesthesia? N Y)

Medications (including prescription medicines, eyedrops, vitamins, herbals, over-the-counter medicines)

Allergies to:	any medicines.....	N	Y	_____
	fluorescein dye.....	N	Y	_____
	iodine or shellfish.....	N	Y	_____
	other (food/envirmonmental)...	N	Y	_____

FAMILY HISTORY

Glaucoma.....	N	Y
Macular degeneration...	N	Y
Retinal detachment.....	N	Y
Blindness.....	N	Y

Relationship to Patient:

List any other eye or medical conditions in your family:

SOCIAL HISTORY

Smoke?	Never	Former, but quit _____ yrs ago	Current (how much) _____
Drink Alcohol?	None	< 1 drink / day	> 1 drink / day (how much) _____

REVIEW OF SYSTEMS

Do you have problems with any of the following?:

Chronic fever, unexpected weight loss/ gain, fatigue	N	Y	_____
Ear/nose/throat (e.g. hearing loss, sinus problem, sore throat)	N	Y	_____
Heart (e.g. chest pain, irregular heart beat)	N	Y	_____
Respiratory (e.g. shortness of breath, wheezing, coughing)	N	Y	_____
Gastrointestinal (e.g. heartburn, abdominal pain, diarrhea, vomiting)	N	Y	_____
Urinary (e.g. pain or discomfort, blood in urine)	N	Y	_____
Skin (e.g. rashes, excessive dryness)	N	Y	_____
Musculoskeletal (e.g. muscle aches, joint pain, swollen joints)	N	Y	_____
Neurologic (e.g. numbness, weakness, headaches, paralysis)	N	Y	_____
Psychiatric (e.g. depression, anxiety)	N	Y	_____

Physician's Signature _____

Date _____