PATIENT HISTORY

Name _____ Birth date _____ Date _____

Would you like more information on any of the following? Refractive Surgery Contact Lenses Cataracts Dry Eye
Diabetic Eye Disease Eyelid Surgery Glaucoma Botox

EYE HISTORY

1. Are you currently experiencing any eye symptoms? Eye Pain Blurred Vision Eyelid Crusting Discharge
   Floaters Light Sensitivity Double Vision Light Flashes
2. Do you wear glasses? □ yes □ no
3. Do you wear contacts? □ yes □ no if yes, what kind? _____
4. Do you have problems reading? □ yes □ no if yes, do you wear reading glasses? □ yes □no
5. Have you ever had an eye injury or eye surgery? □ yes □ no ….. if yes:_____
6. Have you ever had any eye disease? □ yes □ no e.g. glaucoma, cataracts, lazy eye, retinal detachment, macular degeneration
   If yes, please explain: _____
7. Do you take any eye medications? □ yes □ no if yes:_____

MEDICAL HISTORY

1. Do you have any medical conditions? e.g. diabetes, cholesterol, high blood pressure, arthritis, thyroid disorder, gerd
   □ yes □ no if yes, please explain:_____
2. Have you ever had any surgery? □ yes □ no if yes:_____
3. Have you ever been hospitalized for any reason other than surgery? □ yes □ no if yes:_____
4. List your prescription and over-the-counter medications: _____
   _____
   _____
   _____
5. Do you have any drug or food allergies? □ yes □ no if yes:_____

REVIEW OF SYSTEMS

Are you currently or have you recently had any of the following problems:	Yes	No	
Chronic fever, unexpected weight loss/gain, fatigue……	□	□	_____
Ear/nose/throat problems (eg hearing loss, sinusitis, sore throat)…….	□	□	_____
Heart problems (eg chest pain, irregular heart beat)……	□	□	_____
Respiratory problems (eg shortness of breath, wheezing, coughing)……..	□	□	_____
Gastrointestinal problems (eg heartburn, abdominal pain, diarrhea, vomiting)	□	□	_____
Urinary problems (eg pain or discomfort, blood in urine) ……..	□	□	_____
Skin problems (eg rashes, excessive dryness)…….	□	□	_____
Musculoskeletal problems (eg muscle aches, joint pain, swollen joints) …….	□	□	_____
Neurologic problems (eg numbness, weakness, headaches, paralysis) ……..	□	□	_____
Psychiatric problems (eg depression, anxiety)……	□	□	_____

FAMILY AND SOCIAL HISTORY

1. Do any medical or eye diseases run in your family? e.g. diabetes, hypertension, cancer, stroke, glaucoma, macular degeneration
   □ yes □ no If yes, please explain: _____
2. Do you smoke? □ yes □ no If yes, how much? _____ for how many years? _____
3. Do you drink alcohol? □ yes □ no If yes, circle all that apply: daily, weekly, monthly, holidays; wine, beer, liquor
4. If employed, how many hours per week do you work? _____ job title _____

Physician Signature _____ Date _____ Tech init _____

Updated on _____ by _____ changes? □ yes □ no Reviewed by _____, MD
Updated on _____ by _____ changes? □ yes □ no Reviewed by _____, MD
Updated on _____ by _____ changes? □ yes □ no Reviewed by _____, MD
Updated on _____ by _____ changes? □ yes □ no Reviewed by _____, MD