PATIENT HISTORY RECORD

NAME: _____ **DATE:** _____

BIRTH DATE: _____
HEIGHT: _____
WEIGHT: _____
AGE: _____
GENDER: ☐ **Male** ☐ **Female**

Were you referred by another doctor? ☐ **Yes** ☐ **No**

Who?: _____

☐ **Yes** ☐ **No** Do you have allergies to any medication?: (If **YES,** list medications): _____

☐ **Yes** ☐ **No** Have you ever had laser vision correction? ☐ LASIK or ☐ PRK
☐ **Yes** ☐ **No** Have you ever had surgery? _____
☐ **Yes** ☐ **No** Have you ever been hospitalized? _____
☐ **Yes** ☐ **No** Have you ever been treated for any medical conditions, (e.g., diabetes, high blood pressure, arthritis, etc.?)
☐ **Yes** ☐ **No** Have you ever been treated for H.I.V./AIDS?

REVIEW OF SYMPTOMS: (IF "YES," PLEASE EXPLAIN) (OK to use back, draw arrow to back)

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?:

☐ **Yes** ☐ **No** Chronic fever, unexpected weight loss/gain, or fatigue: _____
☐ **Yes** ☐ **No** Ear/nose/throat problems, (e.g., hearing loss, sinus problems, sore throat): _____
☐ **Yes** ☐ **No** Heart problems, (e.g., chest pain, irregular heart beat): _____
☐ **Yes** ☐ **No** Respiratory problems, (e.g., shortness of breath, wheezing, coughing): _____
☐ **Yes** ☐ **No** Gastrointestinal problems, (e.g., heartburn, abdominal pain, diarrhea, vomiting): _____
☐ **Yes** ☐ **No** Urinary problems, (e.g., pain or discomfort, blood in urine): _____
☐ **Yes** ☐ **No** Skin problems, (e.g., rashes, excessive dryness): _____
☐ **Yes** ☐ **No** Musculoskeletal problems, (e.g., muscle aches, joint pain, swollen joints): _____
☐ **Yes** ☐ **No** Neurologic problems, (e.g., numbness, weakness, headaches, paralysis): _____
☐ **Yes** ☐ **No** Psychiatric problems, (e.g., depression, anxiety): _____

FAMILY AND SOCIAL HISTORY:

☐ **Yes** ☐ **No** Do any medical or eye diseases run in your family, (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration?) (If **YES**, please explain): _____
☐ **Yes** ☐ **No** Do you smoke? How much? _____
☐ **Yes** ☐ **No** Do you use alcohol? How much? _____
If employed, occupation? _____ How many hours per week do you work? _____

EYES:

☐ **Yes** ☐ **No** Have you ever had any eye disease, (e.g., glaucoma, cataract, macular degeneration, or retinal detachment?) _____

With your glasses on, do you have difficulty.....
☐ **Yes** ☐ **No** Driving
☐ **Yes** ☐ **No** Driving at night
☐ **Yes** ☐ **No** Reading small print

DO YOU CURRENTLY HAVE PROBLEMS IN THE FOLLOWING AREAS?

☐ **Yes** ☐ **No** Do you take any eye medications?
☐ **Yes** ☐ **No** Loss of vision
☐ **Yes** ☐ **No** Blurred vision
☐ **Yes** ☐ **No** Fluctuating vision
☐ **Yes** ☐ **No** Distorted vision (halos)
☐ **Yes** ☐ **No** Glare or light sensitivity
☐ **Yes** ☐ **No** Loss of side vision
☐ **Yes** ☐ **No** Double vision
☐ **Yes** ☐ **No** Dryness
☐ **Yes** ☐ **No** Mucous discharge
☐ **Yes** ☐ **No** Redness

☐ **Yes** ☐ **No** Sandy or gritty feeling
☐ **Yes** ☐ **No** Itching
☐ **Yes** ☐ **No** Burning
☐ **Yes** ☐ **No** Foreign body sensation
☐ **Yes** ☐ **No** Excess tearing or watering
☐ **Yes** ☐ **No** Eye pain or soreness
☐ **Yes** ☐ **No** Infection of eye or lid
☐ **Yes** ☐ **No** Tired eyes
☐ **Yes** ☐ **No** Crossed eyes, lazy eye
☐ **Yes** ☐ **No** Drooping eyelid

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____