Date:

PATIENT HEALTH HISTORY

Thank you for choosing our practice. To better serve you, please fill out the information below to the best of your ability.

Patient Name *(Last, First, M.I.):*		**Sex:**	**Age:**	**DOB:**
Social Security #:	**Primary Care Physician:**			
Address:	**City:**	**State:**	**Zip:**	
Phone: Home	**Work:**		**Cell::**	
Occupation:	**Employer:**		**Spouse:**	

EYE HISTORY

Do you currently wear?	☐ **Glasses**	☐ **Contact Lens**	☐ **Neither**
Do you visual difficulty when reading?	☐ **No**	☐ **Yes**	
Do you visual difficulty when driving?	☐ **No**	☐ **Yes**	
Are you currently using any prescriptions or non-prescription medication for your eye(s)?	☐ **No**	☐ **Yes**	
If yes, please describe:			
Have you ever had eye surgery?	☐ **No**	☐ **Yes**	
If yes, please describe:			
☐ **Right Eye**	**Type of surgery:**	**Date:**	
	Additional surgery:	**Date:**	
☐ **Left Eye**	**Type of surgery:**	**Date:**	
	Additional surgery:	**Date:**	
Have you ever injured your eye(s)?	☐ **No**	☐ **Yes**	
If yes, please describe:			

Have you ever had any of the following eye conditions:

			Click here if you are currently experiencing this condition				Click here if you are currently experiencing this condition
Glaucoma	☐ **No**	☐ **Yes**	☐	**Halos**	☐ **No**	☐ **Yes**	☐
Macular degeneration	☐ **No**	☐ **Yes**	☐	**Light sensitivity**	☐ **No**	☐ **Yes**	☐
Cataracts	☐ **No**	☐ **Yes**	☐	**Redness**	☐ **No**	☐ **Yes**	☐
Retinal tear or detachment	☐ **No**	☐ **Yes**	☐	**Itching**	☐ **No**	☐ **Yes**	☐
Lazy eye/wandering eye	☐ **No**	☐ **Yes**	☐	**Burning**	☐ **No**	☐ **Yes**	☐
Eye pain	☐ **No**	☐ **Yes**	☐	**Dryness**	☐ **No**	☐ **Yes**	☐
Blurred vision	☐ **No**	☐ **Yes**	☐	**Sandy/gritty sensation**	☐ **No**	☐ **Yes**	☐
Decreased vision	☐ **No**	☐ **Yes**	☐	**Foreign body sensation**	☐ **No**	☐ **Yes**	☐
Double Vision	☐ **No**	☐ **Yes**	☐	**Discharge**	☐ **No**	☐ **Yes**	☐
Flashes of light in eye(s)	☐ **No**	☐ **Yes**	☐	**Crusting on eyelid**	☐ **No**	☐ **Yes**	☐
Floating dark spots in eye(s)	☐ **No**	☐ **Yes**	☐	**Drooping eyelid**	☐ **No**	☐ **Yes**	☐

Other (not listed above): _____

Date of last eye exam: _____ **Date of last office visit:** _____

Reason for office visit: _____

MEDICAL HISTORY
Are you currently being treated for any of the following?
☐ High Blood Pressure ☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Arthritis ☐ Other:
Have you ever been treated for a serious illness or medical condition? ☐ No ☐ Yes
If yes, please describe:
Have you ever had any hospitalization or surgery? ☐ No ☐ Yes
If yes, please describe:
Please list any medications that you take, prescription or non-prescription:
Do you have: Drug allergies? ☐ No ☐ Yes Please list:
Do you have: Food allergies? ☐ No ☐ Yes Please list:
Do you have: Latex allergies? ☐ No ☐ Yes
Who referred you to our office:
REVIEW OF SYSTEMS:
Are you currently experiencing problems with any of the following?
Sudden weight gain or loss? ☐ No ☐ Yes If yes, please explain:
Chronic fever or chronic fatigue? ☐ No ☐ Yes If yes, please explain:
Heart? ☐ No ☐ Yes If yes, please explain: (example: chest pain, angina, irregular heart beat)
Respiratory? ☐ No ☐ Yes If yes, please explain: (example: coughing, wheezing, shortness of breath, asthma)
Gastrointestinal? ☐ No ☐ Yes If yes, please explain: (example: abdominal pain, heartburn, bowel problems, vomiting)
Urinary? ☐ No ☐ Yes If yes, please explain: **(**example: pain when urinating, blood in urine**)**
Hematologic/Lymphatic? ☐ No ☐ Yes If yes, please explain: (example: blood disorders, bruising, cuts heal slowly, enlarged glands)
Endocrine? ☐ No ☐ Yes If yes, please explain: (example: thyroid problems)
Integumentary? ☐ No ☐ Yes If yes, please explain: (example: rashes, dry skin)
Musculoskeletal? ☐ No ☐ Yes If yes, please explain: (example: joint pain, stiffness or swelling, muscle pain or weakness)
Neurological? ☐ No ☐ Yes If yes, please explain: (example: numbness, headache, seizures, paralysis)
Psychiatric? ☐ No ☐ Yes If yes, please explain: (example: depression, anxiety, insomnia, confusion)
Allergic/Immunologic? ☐ No ☐ Yes If yes, please explain: (example: reaction to food or drugs, allergies, hay fever)

SOCIAL HISTORY:

Martial status:	**☐ Single**	**☐ Married**	**☐ Separated**	**☐ Divorced**	**☐ Widowed**
Use of alcohol:	**☐ Never**	**☐ Rarely**	**☐ Moderate**	**☐ Daily**	**How much?**
Use of tobacco:	**☐ Never**	**☐ Previously,**	**but not in the past ___ years**		**☐ Yes _____ packs/day**

FAMILY HISTORY:

	Age	Medical/Eye Disease	If deceased, cause of death
Father			
Mother			
Siblings			
Children			
Spouse			

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status or condition.

_____ _____

Signature of patient (or guardian, if minor) **Date**

_____ _____

Physician's signature **Date**