PATIENT HISTORY

NAME: ______________________________

DATE: ______________________________

Please check if you have not had any changes in medication or health within the last year ❑

REASON FOR EXAM: ❑Eye health concern ❑Floaters ❑Headaches ❑Blur ❑Night vision ❑Glasses ❑Contact Lenses
Other:

FAMILY DOCTOR: ____ **DR. PHONE:** ___________________________

RACE/ ETHNICITY: Hispanic/Latino Asian/ Pacific Islander Black/ African American White Other:

REVIEW OF SYSTEMS: ***Please mark any conditions that apply.***

CONSITUTION: Cancer, Fatigue, Disability, Weight gain/loss, Other_____________________________________ ❑None

ENT: Sinusitis, Laryngitis, Dry mouth, Hearing loss, Other____ ❑None

NEURO: Epilepsy, Brain tumor, Migraine, MS, Stroke/CVA, Cerebral palsy, Other__________________________ ❑None

PSYCHIATRIC: Attention deficit, Depression, Anxiety, Bipolar, Other ___________________________________ ❑None

CARDIOVASC: Heart disease, Hypertension, Vascular disease, Other____________________________________ ❑None

RESPIRATORY: Asthma, Bronchitis, COPD, Emphysema, Sleep apnea, Other______________________________ ❑None

GI: Ulcer, Acid reflux, Colitis, Crohn's, Celiac, Other____ ❑None

GU: Prostate cancer, Benign prostate hypertrophy, Pregnant, Nursing, Herpes/Chlamydia, Other_____________ ❑None

MUSC/SKEL: Rheumatoid arthritis, Osteoarthritis, Osteoporosis, Gout, MD, Other_________________________ ❑None

SKIN: Eczema, Psoriasis, Rosacea, Cold sores, Shingles, Other____ ❑None

ENDOCRINE: Diabetes (Type1/Type2), Thyroid, Hormone dysfunction, Other_____________________________ ❑None

BLOOD/LYMPH: High cholesterol, Anemia, Ulcer, Large-volume blood loss, Other__________________________ ❑None

ALLERGY/IMMUNE: Sjogren's Syndrome, Auto-immune disorder______________________________________ ❑None

ENVIRONMENTAL: Seasonal, Dust/molds, Pets, Latex, Food, Other _____________________________ ❑None

DRUG ALLERGIES: Penicillin, Sulfa, Opiods, Other____ ❑None

EYE HISTORY: Eye surgery, Cataract surgery, Amblyopia (weak eye), Eye injury, Glaucoma, Strabismus (eye turn), Macular degeneration, Keratoconus, Glaucoma suspect, Cataract, Retinal detachment ❑None
Other:

FAMILY EYE HISTORY: Cataract, Amblyopia (weak eye), Retinal detachment, Glaucoma suspect, Macular degeneration, Glaucoma, Strabismus (eye turn), Keratoconus ❑None
Other:

FAMILY MEDICAL HISTORY: Cancer, Hypertension, Cardiovascular, Diabetes, Thyroid, Stroke ❑None ❑Adopted
Other:

SOCIAL HISTORY: Alcohol: ❑Yes ________/week ❑No
Tobacco Use: ❑Yes ______PPD ❑No (❑Never smoker, ❑Former smoker)

CONTACT LENSES: ❑Current wearer ❑Occasional wearer ❑Interested in wearing contacts