PATIENT HISTORY

Patient Name: ______________________________ DOB____/____/______ Gender M F

Race __________ Ethnicity __________________ Preferred Language ____________________

E-mail address ____________________________ How do you prefer that we contact you?____________________

Primary Care Physician: ____________________ Date Last Seen: __________ Occupation: __________

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include prescriptions, over the counter, vitamins and herbal therapies):

____

____

List all major surgeries (Eye Surgery included):

____

List any allergic reactions to medications or eye drops:

____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself Yes	Yourself No
Cataract	·	·
Eye Turn	·	·
Glaucoma	·	·
Macular Degeneration	·	·
Retinal Detachment	·	·

	Yes	No
Women- Are you pregnant?	·	·
Are you breast feeding?	·	·

	Family Member Yes	Family Member No	Relationship (Blood Relatives Only)
Blindness	·	·	______________
Eye Turn	·	·	______________
Glaucoma	·	·	______________
Macular Degeneration	·	·	______________
Retinal Detachment	·	·	______________

Other:____

Review of Systems Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
- None
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Seasonal Allergies
- Other (i.e., Latex)

Ear, Nose and Throat
- None
- Sinusitis
- Upper Respiratory Tract Infection
- Other

Gastrointestinal
- None
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other

Skin/Integumentary
- None
- Eczema
- Rosacea
- Psoriasis
- Other

Psychiatric
- None
- Depression
- Bi-Polar
- Schizophrenia
- Other

Cardiovascular
- None
- High Blood Pressure
- Heart Disease
- Stroke
- Vascular Disease
- High Blood Cholesterol

Endocrine/Glands
- None
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other

Respiratory
- None
- Asthma
- Bronchitis
- Emphysema
- Other

Muscle/Skeletal
- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other

Genital/Urinary
- None
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other

Hematologic/Lymphatic
- None
- Anemia
- Leukemia
- Bleeding Disorder
- Other

Neurological
- None
- Multiple Sclerosis
- Epilepsy
- Memory problems
- Other

General Health
- None
- Weight loss/gain
- Fever
- Fatigue
- Trauma

Social
- Tobacco Use: Current Smoker Former Smoker
- Non-Prescription Drugs________________
- Alcohol Consumption________________

Please sign below to acknowledge that this form is current:

Signature: ______________________________ Date: ________________ Reviewed by Doctor: ______________