PATIENT HISTORY Date_____

Name_____ Birthdate_____

Primary Care Physician _____

Did anyone refer you to our office?_____

MEDICAL HISTORY

Current or past eye conditions, eye injuries, laser treatments, and eye surgeries (e.g. "lazy" eye)

_____

_____

Current or past medical conditions (e.g. diabetes, high blood pressure, heart, asthma, arthritis, thyroid)

_____

_____

Any other surgeries with dates (If you have had surgery, any problems with anesthesia? N Y)

_____

_____

Medications (including prescription medicines, eyedrops, vitamins, herbals, over-the-counter medicines)

_____

_____

Allergies to:
- any medicines…….. N Y _____
- fluorescein dye…… N Y _____
- iodine or shellfish…….. …. N Y _____
- other (food/envirmonmental)… N Y _____

FAMILY HISTORY

		Relationship to Patient:	List any other eye or medical conditions in your family:
Glaucoma……N	Y	_____	
Macular degeneration…N	Y	_____	_____
Retinal detachment…….N	Y	_____	_____
Blindness……N	Y	_____	_____

SOCIAL HISTORY

Smoke? Never Former, but quit _____ yrs ago Current (how much) _____

Drink Alcohol? None < 1 drink / day > 1 drink / day (how much) _____

REVIEW OF SYSTEMS

Do you have problems with any of the following?:

Chronic fever, unexpected weight loss/ gain, fatigue	N	Y _____
Ear/nose/throat (e.g. hearing loss, sinus problem, sore throat)	N	Y _____
Heart (e.g. chest pain, irregular heart beat)	N	Y _____
Respiratory (e.g. shortness of breath, wheezing, coughing)	N	Y _____
Gastrointestinal (e.g. heartburn, abdominal pain, diarrhea, vomiting)	N	Y _____
Urinary (e.g. pain or discomfort, blood in urine)	N	Y _____
Skin (e.g. rashes, excessive dryness)	N	Y _____
Musculoskeletal (e.g. muscle aches, joint pain, swollen joints)	N	Y _____
Neurologic (e.g. numbness, weakness, headaches, paralysis)	N	Y _____
Psychiatric (e.g. depression, anxiety)	N	Y _____

Physician's Signature _____ Date _____