Name_____

Date_____

Patient History Form

New patients and return patients with last exam > 1 year ago

The doctor or person who referred you:
Name: _____
Address: _____
_____
Phone: _____

List any eye drops that you currently use:
_____
_____

List any medications/vitamins that you are taking:
_____
_____
_____

List any allergies to medications/food/latex you have:
_____

Why did you come to see us today?
(check all that apply)

□ I have an eye disease requiring examination:
_____

□ I want a prescription for glasses.
□ I want contact lenses.
□ I am not having any specific eye problems.
□ I would like a second opinion.
□ I am having the following problems:
_____
_____
_____

I will be using my : **□ vision insurance**

□ medical insurance
□ I will pay personally

Social / Environmental History

Current occupation _____
Day-time phone # _____
Marital status _____
Do you live in □own home □with relatives
□retirement facility □other_____
Are you pregnant? □yes □no If so, when due?_____
Do you smoke? □yes □no If so, _____packs/ day
Do you drink alcohol? □yes □no If so, ____drinks/day

Your personal medical doctor

Name: _____
Address: _____
_____
Phone: _____

Previous eye doctors: _____

Do you wear contact lens? □yes □no
My lenses are □soft □rigid gas permeable
I have worn contact lenses for_____years.
My cleaning solution is: _____
_____

Tell us about your past eye history:

Have you ever had an eye injury: □yes □no
If so, describe: _____
_____
_____

Do you have any eye disease you know of, or chronic problems with your eyes? □yes □no
If so, describe: _____
_____
_____

Who would you like to participate in your care, and with whom may we discuss medical information?
Spouse?_____ Family members? _____
_____

****PLEASE CONTINUE ON THE BACK SIDE****

Patient Name_____ Date _____

Do you currently have or have you had (specify date if not current) any of the following problems?

	Yes	No	Date/ explanation of Problem
Fever			
Weight loss			
Ear, nose, or throat problems			
Heart Attack or heart failure (circle)			
Angina or chest pain			
Irregular heart beat or pacemaker (circle)			
High blood pressure			
Blood clots in your legs			
Asthma			
Emphysema or bronchitis (circle)			
Pneumonia or tuberculosis (circle)			
Liver disease or jaundice			
Stomach or duodenal ulcers			
Urination difficulty, kidney disease or stones			
Stroke or seizures (circle)			
Migraines			
Psychiatric treatment			
Diabetes. If so, for how long?			
Thyroid problems			
Bleeding disorder or anemia (circle)			
Transfusions of blood or plasma			
AIDS or HIV positive test			
Cancer or tumors			
Arthritis (if yes, what type)			

Family history – Among your blood relatives, is there a history of:

	Yes	No	Explanation of Problem/ Relationship to you
Diabetes			
Tumor or cancer			
High blood pressure or heart disease (circle)			
Multiple Sclerosis			
Bleeding disorder			
Problems with anesthetic			
Glaucoma			
Cataracts			
Lazy eye/ Crossed eye/ Muscle imbalance (circle)			
Retina or macular disease			
Color or night blindness			
Unexplained vision loss			

List all other major illnesses or injuries or toxic exposures not mentioned above:

List any surgeries, eye or non-eye:

Doctor's signature on review: