PATIENT HISTORY RECORD

_____

Patient Name Date

_____

Family Doctor Name, Address and Telephone Number

_____

Emergency Contact Name Relationship Telephone Number

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR MEDICAL HISTORY:

1. Do you have any drug or food allergies?
   Yes___ No___ If YES, please list_____

   _____

2. Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or “lazy eye”, retinal detachment)?
   Yes___ No___ If YES, please explain_____

   _____

3. Do you take any eye medications?
   Yes___ No___ If YES, please list_____

   _____

4. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)?
   Yes___ No___ If YES, please explain_____

   _____

5. Do you take any medications?
   Yes___ No___ If Yes, please list_____

   _____

   _____

6. Have you ever had any surgery?
   Yes___ No___ If YES, please give date and reason_____

   _____

7. Have you ever been hospitalized?
   Yes___ No___ If YES, please give date and reason_____

   _____

(PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE OF FORM)

REVIEW OF SYSTEMS

Do you currently have any of the following problems?

	YES	NO	If YES, please explain
Chronic fever, unexpected weight gain/loss, fatigue	___	___	_____
Ear/nose/throat problems (e.g.) hearing loss, sinus problems, sore throat)	___	___	_____
Heart problems (e.g. chest pain, irregular hear beat)	___	___	_____
Respiratory problems (e.g. shortness of breath,coughing)	___	___	_____
Gastrointestinal problems (e.g. heartburn, diarrhea, vomiting, abdominal pain)	___	___	_____
Urinary problems (e.g. pain, discomfort, blood in urine)	___	___	_____
Skin problems (e.g. rashes, excess dryness)	___	___	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	___	___	_____
Neurologic problems (e.g. weakness, headaches)	___	___	_____
Psychiatric problems (e.g. depression, anxiety)	___	___	_____

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

Yes___ No___ If YES, please explain:_____

_____

Do you smoke? Yes___ No___. If yes, how much?_____

Do you drink alcohol? Yes___ No___. If yes, how much?_____

Patient Signature_____