Patient History Form

Patient: ____________________________ Date: ____________ OD: _______________ MD: _______________

Occupation: _______________________ Do you Smoke? ____ Do you drink Alcohol? ____ Do you drive? ____

Do these diseases run in your immediate family? (mother, father, brother, or sister)

	Yes	No	Relationship		Yes	No	Relationship
Glaucoma	❑	❑	_________________	Cataracts	❑	❑	__________________
Crossed/Lazy Eye	❑	❑	_________________	Diabetes	❑	❑	__________________
Retina Disease	❑	❑	_________________	Other	❑	❑	__________________

Have you ever had the following eye diseases?

	Yes	No		Yes	No	
Cataracts	❑	❑	Glaucoma	❑	❑	If yes, are taking drops? ____
Retina Disease	❑	❑	Crossed/Lazy Eye	❑	❑	When ________ Eye ______
Long Term Steroid Use	❑	❑	Trauma/Injury	❑	❑	

Have you ever had eye surgery?

	Type of surgery?	Which eye?	When?	Surgeon's Name?
1.	_________________________	____________	_____________	________________________________
2.	_________________________	____________	_____________	________________________________
3.	_________________________	____________	_____________	________________________________

Review of Systems

Do you currently have any of the following problems?

	Yes	No		Yes	No
Weight loss, Fever	❑	❑	Ear/Nose/Throat/Hearing Loss/Sinus/other	❑	❑
Heart Problems (Chest Pain, Irregular Beat)	❑	❑	Skin (Rashes, Excessive Dryness)	❑	❑
Gastrointestinal (Heartburn, Abdominal Pain)	❑	❑	Endocrine (Diabetes, Thyroid condition)	❑	❑
Respiratory (Shortness of Breath, Wheezing)	❑	❑	Musculoskeletal (Joint Aches)	❑	❑
Neurological (Numbness, Headaches, etc)	❑	❑	Psychiatric (Depression, Anxiety)	❑	❑
Urinary (pain or discomfort, Blood in Urine)	❑	❑	Anemia, Leukemia, Lymphoma	❑	❑

Explain all yes answers:____

Have you been treated for any medical conditions? (e.g. diabetes, high blood pressure, arthritis, etc?)
Yes ____ No ____ If Yes, please explain.____

Past Surgeries: Type of surgery & date   Type of surgery & date   Type of surgery & date

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Allergies: ____

Medications:_________________________ ____________________________ __________________________

_________________________ ____________________________ __________________________

_________________________ ____________________________ __________________________

_________________________ ____________________________ __________________________

_________________________ ____________________________ __________________________

Office staff use only:

Updated on: ___________________, ____________________, ______________________, _________________

Physicians Signature: ______________________________ Date: ____________________ Tech Initials:_________