

# PATIENT HISTORY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Age \_\_\_\_\_ M/F Occupation \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Primary Physician \_\_\_\_\_ Physician Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

## MEDICAL INFORMATION

(Please circle Y or N)

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/lymph	Y/N
Allergic/immunologic	Y/N	Other	Y/N		

Please explain \_\_\_\_\_

Last Physical Exam \_\_\_\_\_

Headaches frequent/rarely/never Any recent changes in headaches? Y/N Explain \_\_\_\_\_

Diabetes Y/N Type \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_ Last Fasting Glucose \_\_\_\_\_ Last A1C \_\_\_\_\_ Last Triglyceride \_\_\_\_\_

Hypertension Y/N Last Blood Pressure \_\_\_\_\_ HIV Y/N

Allergies Y/N To What? \_\_\_\_\_ What happens? \_\_\_\_\_

Medication Allergy Y/N To What? \_\_\_\_\_ What happens? \_\_\_\_\_

Current Medication(s) \_\_\_\_\_ Dosage: \_\_\_\_\_

\_\_\_\_\_ Dosage: \_\_\_\_\_

Have you had any Operations? Y/N Kind? \_\_\_\_\_ When? \_\_\_\_\_

Cigarettes/Tobacco: Smoker: Every Day/Some Days Former Smoker Never Smoked

Alcohol frequent/occasional/never Other substance(s) \_\_\_\_\_

## FAMILY HISTORY

(please circle Y or N)

Glaucoma Y/N Relation \_\_\_\_\_ Macular Degeneration Y/N Relation \_\_\_\_\_

Cataracts Y/N Relation \_\_\_\_\_ Retinal Detachment Y/N Relation \_\_\_\_\_

Diabetes Y/N Relation \_\_\_\_\_ High Blood Pressure Y/N Relation \_\_\_\_\_

Other Eye Condition(s) Y/N Type \_\_\_\_\_ Relation \_\_\_\_\_

## PERSONAL EYE INFORMATION

Last Eye Exam Date and Doctor's Name: \_\_\_\_\_

Do you wear glasses? Y/N Distance/Reading/Both Blur at distance or near without glasses? Y/N

Blur while wearing glasses for distance? Y/N Blur while wearing glasses for reading? Y/N

Contact Lenses Y/N Type \_\_\_\_\_ Blurry Vision with contact lenses Y/N

Are your contact lenses comfortable? Y/N Normal wearing time \_\_\_\_\_ Solution Type \_\_\_\_\_

Contact Lens Replacement Schedule daily/2 weeks/monthly/ quarterly/ yearly/other \_\_\_\_\_

Have you had an eye operation? Y/N Type \_\_\_\_\_ Date \_\_\_\_\_

Have you had an eye injury? Y/N Type \_\_\_\_\_ Date \_\_\_\_\_

Glaucoma Y/N Cataracts Y/N

Additional Information \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_