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 _____