

PATIENT HISTORY

Patient Name: _____ DOB ____/____/____ Gender M F
 Race _____ Ethnicity _____ Preferred Language _____
 E-mail address _____ How do you prefer that we contact you? _____
 Primary Care Physician: _____ Date Last Seen: _____ Occupation: _____

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include prescriptions, over the counter, vitamins and herbal therapies):

List all major surgeries (Eye Surgery included):

List any allergic reactions to medications or eye drops:

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself			Yes	No
	Yes	No			
Cataract	.	.	Women- Are you pregnant?	.	.
Eye Turn	.	.	Are you breast feeding?	.	.
Glaucoma	.	.			
Macular Degeneration	.	.			
Retinal Detachment	.	.			
	Family Member		Relationship (Blood Relatives Only)		
	Yes	No			
Blindness	.	.			
Eye Turn	.	.			
Glaucoma	.	.			
Macular Degeneration	.	.			
Retinal Detachment	.	.			
Other: _____					

Review of Systems

Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic

- None
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Seasonal Allergies
- Other (i.e., Latex)

Ear, Nose and Throat

- None
- Sinusitis
- Upper Respiratory Tract Infection
- Other

Gastrointestinal

- None
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other

Skin /Integumentary

- None
- Eczema
- Rosacea
- Psoriasis
- Other

Psychiatric

- None
- Depression
- Bi-Polar
- Schizophrenia
- Other

Cardiovascular

- None
- High Blood Pressure
- Heart Disease
- Stroke
- Vascular Disease
- High Blood Cholesterol

Endocrine /Glands

- None
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other

Respiratory

- None
- Asthma
- Bronchitis
- Emphysema
- Other

Muscle /Skeletal

- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other

Genital/Urinary

- None
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other

Hematologic/Lymphatic

- None
- Anemia
- Leukemia
- Bleeding Disorder
- Other

Neurological

- None
- Multiple Sclerosis
- Epilepsy
- Memory problems
- Other

General Health

- None
- Weight loss/gain
- Fever
- Fatigue
- Trauma

Social

- Tobacco Use: Current Smoker _____ Former Smoker _____
- Non-Prescription Drugs _____
- Alcohol Consumption _____
- Weight _____ Height _____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor: _____