Patient History Form

Patient Name ______________________________ Date ____________

Birth Date ____________ Referred by ______________________________

REVIEW OF SYSTEMS *Do you currently have any of the following problems?*		If YES, please explain.
1. Please list medication you are taking, including eye drops.		
2. Do you have any allergies to any medication?	¨ Yes ¨ No	
3. **Constitutional** (fever, weight loss, other)	¨ Yes ¨ No	
4. **Eyes** (glaucoma, cataract, lazy eye, retina problems, other - please specify)	¨ Yes ¨ No	
5. **Ear / nose / mouth / throat** (hearing loss, sinus problems, sore throat)	¨ Yes ¨ No	
6. **Cardiovascular** (heart problems, chest pain, irregular heart beat)	¨ Yes ¨ No	
7. **Respiratory** (asthma, shortness of breath, wheezing, coughing)	¨ Yes ¨ No	
8. **Gastrointestinal** (heartburn, abd. pain, diarrhea, vomiting)	¨ Yes ¨ No	
9. **Genitourinary** (urinary problems, blood in urine)	¨ Yes ¨ No	
10. **Integumentary** (skin rashes, excessive dryness)	¨ Yes ¨ No	
11. **Musculoskeletal** (muscle aches, joint pain, swollen joints)	¨ Yes ¨ No	
12. **Neurological** (numbness, weakness, headaches, paralysis)	¨ Yes ¨ No	
13. **Hematologic/Lymphatic** (blood disorders, leukemia)	¨ Yes ¨ No	
14. **Allergic/Immunologic** (hay fever, allergies)	¨ Yes ¨ No	
15. **Endocrine** (thyroid problems)	¨ Yes ¨ No	
16. **Psychiatric** (depression, anxiety)	¨ Yes ¨ No	

Family and social history: Do any medical or eye diseases run in your family. If YES, Please note relationship to patient.

¨ Glaucoma ____________

¨ Diabetes ____________ Do you smoke? If YES, how much? ¨ Yes ¨ No

¨ High blood pressure ____________ How much: ____________

¨ Macular degeneration ____________ Drink alcohol? If YES, how much? ¨ Yes ¨ No

¨ *Other* ____________ How much: ____________

Comments:

Physician's Signature: ______________________________ *Date:* ____________