

PATIENT HISTORY RECORD

Patient Name _____ Date of Birth _____ Soc Sec. # _____

Primary Care Physician: _____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions? (e.g., diabetes, high blood pressure, arthritis, etc.)
YES () NO () If yes, please explain: _____
2. Have you ever had any eye disease? (e.g., glaucoma, cataracts, wandering or "lazy" eye, retinal detachment, etc.)
YES () NO () If yes, please explain: _____
3. Have you ever had any surgery?
YES () NO () If yes, please provide date & reason: _____
4. Have you ever been hospitalized?
YES () NO () If yes, please provide date & reason: _____
5. Do you take any medications? YES () NO () If yes, please list: _____
6. Do you have any drug or food allergies? YES () NO () If yes, please list: _____

REVIEW OF SYMPTONS:

Do you have any of the following problems? If yes, please explain:

- Chronic Fever, unexpected loss/gain of weight, fatigue..... YES () NO () _____
- Ear/nose/throat problems? (hearing loss, sore throat).....YES () NO () _____
- Heart problems? (chest pain, irregular heart beat)..... YES () NO () _____
- Respiratory problems? (shortness of breath, coughing)..... YES () NO () _____
- Gastrointestinal problems? (heartburn, vomiting)..... YES () NO () _____
- Urinary problems? (pain, discomfort, blood in urine)..... YES () NO () _____
- Skin problems? (rashes, excessive dryness)..... YES () NO () _____
- Musculoskeletal problems? (muscles aches, joint pain)..... YES () NO () _____
- Neurological problems? (numbness, headaches, paralysis)..YES () NO () _____
- Psychiatric problems? (depression, anxiety)..... YES () NO () _____

FAMILY AND SOCIAL HISTORY:

Do any medical or eye diseases run in your family? (diabetes, high blood pressure, cancer, glaucoma)
YES () NO () If yes, please explain: _____

Do you smoke? If yes, how much? _____ Drink alcohol? If yes, how much? _____

If employed, how many hours a week do you work? _____

Comments: _____

Doctor's Signature _____ Date _____