Patient Name: ___________________Date of Birth: _________ Account #:________Date:_____

List any MEDICATIONS you currently take including INHALERS, INTRAVENOUS, and/or TOPICAL medications:____

____

List any EYE DROPS you currently use: ____

Do you have ALLERGIES to any medications? ☐ YES ☐ NO If YES, list allergies and reactions:

____

PERSONAL PAST MEDICAL HISTORY: Have you ever had the following <u>diseases</u>?

YES	NO		YES	NO	
☐	☐	**Glaucoma** (eye - right left)	☐	☐	**Anemia**
☐	☐	**Cataract** (eye - right left)	☐	☐	**Asthma/Emphysema**
☐	☐	**Retinal detachment** (eye - right left)	☐	☐	**Pneumonia**
☐	☐	**Eye injury/infection**(eye - right left)	☐	☐	**Hepatitis** *Type?* _____
☐	☐	**Amblyopia** (eye - right left)	☐	☐	**Arthritis or Rheumatoid Arthritis**
☐	☐	**Eye Surgeries** ____________________	☐	☐	**Thyroid problems**
☐	☐	**Diabetes** ☐Type 1 ☐Type 2 *Since when?* _____	☐	☐	**Multiple Sclerosis**
☐	☐	**High Blood Pressure** *Since when?* ______	☐	☐	**Epilepsy**
☐	☐	**Stroke** *When?* _________	☐	☐	**Tuberculosis**
☐	☐	**Heart Attack** *When?* _______	☐	☐	**Migraine headaches**
☐	☐	**Coronary Artery Disease**	☐	☐	**Ulcers of stomach**
☐	☐	**Congestive Heart Failure**	☐	☐	**Herpes**
☐	☐	**Cancer** *Type?* ________*Since When?*_____	☐	☐	**Shingles**
☐	☐	**Venereal Disease (STD)** *Type?* _____	☐	☐	**Lupus**
☐	☐	**Have you ever used IV drugs?**	☐	☐	**Have you been exposed to the AIDS virus (HIV)?**
☐	☐	**Are you pregnant?**			
☐	☐	**Have you ever gone in to Anaphylactic shock?**	☐	☐	**Have you ever had a blood transfusion?**

Below, list all major *illnesses* or *injuries,* or *<u>surgery</u>* not described above:

____

SOCIAL HISTORY:

- Do you drink alcohol? ☐YES ☐NO How often? ______
- Have you ever smoked? ☐YES ☐NO Quit in:________
- Substance abuse currently or in your past?☐YES ☐NO
- Do you currently wear contacts or glasses? ☐YES ☐NO
- Do you drive? ☐YES ☐NO
- Do you have difficulty when driving? ☐YES ☐NO
- Current Occupation: ______________________
- Are you single, married, divorced, or widowed? *(please circle one)*
- Have you ever lived outside the USA? ☐YES ☐NO
- **Preferred Language:** ______________________
- **Race:** ___________ OR
  ☐ I decline to give this information.
- **Ethnicity:** Hispanic Origin, Not of Hispanic Origin, OR
  ☐ I decline to give this information.

FAMILY HISTORY: Has anyone in your IMMEDIATE family had:

☐Retinitis Pigmentosa *who?*______
☐Glaucoma *who?*________
☐Macular Degeneration *who?*______
☐Retinal Detachment *who?*_______
☐High Blood Pressure *who?*_______
☐Diabetes *who?*_______
☐Blindness *who?*_________
☐Cancer *who?* _______
☐Tuberculosis *who?*_______
☐Heart Disease *who?* ______
☐Stroke *who?*_________

Name: ______________________ Date of Birth: ____________ PATIENT HISTORY PAGE 2

REVIEW OF SYSTEMS: Do you currently have any problems in the following areas?

Cardiovascular (heart/blood vessels)

YES	NO	
☐	☐	Chest pain
☐	☐	Irregular heart beat
☐	☐	Difficulty controlling blood pressures
☐	☐	Swelling of the feet

Constitutional Symptoms

YES	NO	
☐	☐	Fever
☐	☐	Weight Loss/Poor Appetite
☐	☐	Fatigue/Tire Easily

Endocrine

YES	NO	
☐	☐	Thyroid problems
☐	☐	Excessive thirst
☐	☐	Excessive urination
☐	☐	Difficulty controlling blood sugars
☐	☐	Cold/heat intolerance

Gastrointestinal

YES	NO	
☐	☐	Stomach pain
☐	☐	Diarrhea
☐	☐	Nausea

Genitourinary (genitals/kidney/bladder)

YES	NO	
☐	☐	Burning with urination
☐	☐	Genital sores
☐	☐	Kidney infection or bleeding

Hematology/Oncology

YES	NO	
☐	☐	Easy Bruising
☐	☐	Prolonged Bleeding

Ears, Nose, Mouth, Throat

YES	NO	
☐	☐	Recent viral infection
☐	☐	Sore throat
☐	☐	Loss of hearing or deafness
☐	☐	Dryness of mouth

Integumentary/Skin

YES	NO	
☐	☐	Change in mole
☐	☐	Rashes/Facial acne

Musculoskeletal

YES	NO	
☐	☐	Muscle aches
☐	☐	Joint pains or stiffness
☐	☐	Back pains or stiffness

Neurological

YES	NO	
☐	☐	Severe headache
☐	☐	Numbness or tingling of extremities
☐	☐	Seizures
☐	☐	Scalp tenderness

Respiratory

YES	NO	
☐	☐	Chronic bronchitis/emphysema
☐	☐	Chronic cough
☐	☐	Shortness of breath

Psychiatric

YES	NO	
☐	☐	Depression/Grieving/Anxiety

Eyes

YES	NO	
☐	☐	Loss of vision
☐	☐	Distorted vision
☐	☐	Double vision
☐	☐	Floating objects in vision
☐	☐	Flashing lights
☐	☐	Dryness of eyes
☐	☐	Itching or Redness
☐	☐	Excess Tearing
☐	☐	Eye pain or soreness

Allergic/Immunologic

YES	NO	
☐	☐	Hives
☐	☐	Frequent severe infections

Patient Signature ____________________________ Date_____________

Physician Signature __________________________ Date_____________