Patient History Form

Patient Name ________________ Date _____________________

Birth Date __________________ Referring Doctor____________

		If yes please explain
1. Please list medications you are taking including eye drops	1. 2. 3. 4. 5. 6. 7. 8.	
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/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 _______________
- High blood pressure _______________
- Macular degeneration _______________
- Other _______________

Do you smoke? If YES, how much? ________

Drink Alcohol? If YES, how much? ________

Comments: ____

Physician Signature ________________________________ Date ________________