

Patient Health History

Date of last physical exam? _____ Date of last eye examination? _____

List all medications you currently take (prescription and over-the-counter): _____

Do you have known allergies to any medications? ☐ Yes ☐ No

If yes, please list: _____

List all eye diseases (glaucoma, diabetic retinopathy, cataracts, etc.) or eye injuries (car accidents, metal in the eye, etc.):

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.): _____

Do you currently have any problems in the following areas?

- | | | |
|---|--|--|
| ☐ Loss of vision | ☐ Blurred vision | ☐ Fluctuating vision |
| ☐ Distorted vision | ☐ Loss of side vision | ☐ Double vision |
| ☐ Tired eyes | ☐ Crossed eye/lazy eye | ☐ Drooping eye lid |
| ☐ Floaters | ☐ Flashes of light | ☐ Itching |
| ☐ Burning | ☐ Redness | ☐ Foreign body sensation |
| ☐ Glare (halos) | ☐ Light sensitivity | ☐ Excess tearing/watering |
| ☐ Eye pain/soreness | ☐ Mucous discharge | ☐ Dryness |
| ☐ Sandy/gritty feeling | ☐ Infection of eye/eyelid | |

If this examination is for a school age child, please answer the following questions. Does your child...

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| ☐ | ☐ | Complain of headaches at school? | ☐ | ☐ | Lose his/her place while reading? |
| ☐ | ☐ | Report eye strain when reading? | ☐ | ☐ | Say that words run together when reading? |
| ☐ | ☐ | Has an involuntary eye turn been observed? | | | |

Family History-does anyone in your family have any of the following conditions?

(Relation key code: M=mother, F=father, B=brother, S=sister, GM=grandmother, GF=grandfather)

- | | |
|---|--------------------------------|
| ☐ Blindness | Relationship to patient: _____ |
| ☐ Glaucoma | Relationship to patient: _____ |
| ☐ Macular Degeneration | Relationship to patient: _____ |
| ☐ Retinal Detachment | Relationship to patient: _____ |
| ☐ Diabetes | Relationship to patient: _____ |
| ☐ Heart Disease | Relationship to patient: _____ |
| ☐ High Blood Pressure | Relationship to patient: _____ |
| ☐ Cancer | Relationship to patient: _____ |
| ☐ Stroke | Relationship to patient: _____ |
| ☐ Other: _____ | Relationship to patient: _____ |

Check all medical conditions that apply to you.

Allergic/ Immunologic:	☐ Drug allergy	☐ Rheumatoid arthritis	☐ Other, explain: _____
	☐ Environmental allergy	☐ Lupus	_____
Musculoskeletal:	☐ Fibromyalgia	☐ Osteoarthritis	☐ Other, explain: _____
	☐ Muscular dystrophy	☐ Ankylosing spondylitis	_____
Cardiovascular:	☐ Heart disease	☐ Stroke	☐ Other, explain: _____
	☐ Hypertension	☐ Vascular disease	_____
Gastrointestinal:	☐ Crohn's disease	☐ Stomach ulcer	☐ Other, explain: _____
	☐ Colitis	☐ Digestive problems	_____
Neurological:	☐ Multiple sclerosis	☐ Alzheimer's	☐ Cerebrovascular
	☐ Epilepsy	☐ Parkinson's	☐ Other, explain: _____
Constitutional symptoms	☐ Developmental disability	☐ Fever	☐ Trauma
	☐ Weight loss	☐ Fatigue	☐ Other, explain: _____
Genitourinary:	☐ STD	☐ Kidney disease	☐ Other, explain: _____
Psychiatric:	☐ Depression	☐ Schizophrenia	
	☐ Panic disorder	☐ Other, explain: _____	
Ears, nose, throat:	☐ Upper resp. tract infection	☐ Runny nose	☐ Sore throat
	☐ Ear ache	☐ Ringing/tinnitus	☐ Other, explain: _____
Hematologic Lymph:	☐ Anemia	☐ Leukemia	☐ Other, explain: _____
	☐ Large volume blood loss	☐ High cholesterol	_____
Respiratory:	☐ Asthma	☐ Emphysema	
	☐ Bronchitis	☐ Other, explain: _____	
Endocrine:	☐ Hormonal dysfunction	☐ Diabetes: insulin or non-insulin dependent	
	☐ Thyroid disease	☐ Other, explain: _____	
Skin:	☐ Eczema	☐ Rosacea	
	☐ Psoriasis	☐ Other, explain: _____	

Social History: Answer only of pertinent to you.

Do you smoke? ☐ yes ☐ no If yes, how much? ☐ Occasional ☐ ½ pack/day ☐ 1 pack/day ☐ 1+ pack/day

If yes, how long have you smoked? _____ If stopped, how long did you smoke? _____

Do you drink alcohol? ☐ yes ☐ no If yes, how much? ☐ Occasional ☐ 1/day ☐ 2-3/day ☐ 4+/day

Do you have problems with glare at night? ☐ yes ☐ no Are you interested in Lasik? ☐ yes ☐ no

Have you ever tried contact lenses? ☐ yes ☐ no

Do you currently wear contact lenses? ☐ yes ☐ no If yes, when did you start? _____

Do you currently wear glasses? ☐ yes ☐ no If yes, how old is your current pair? _____

Do you drive? ☐ yes ☐ no If yes, do you have visual difficulty with driving? ☐ yes ☐ no

Females only: Are you pregnant? ☐ yes ☐ no Breastfeeding? ☐ yes ☐ no