Patient History Record

Patient's Name | Birth Date | Sex | Age

Address | Phone Number

Employer | Occupation | Work Phone Number

Social Security Number | 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, etc)
   ( ) Yes ( ) No If yes, please explain_____
2. Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy eye", retinal detachments)?
   ( ) Yes ( ) No If yes, please explain:_____
3. Have you ever had any surgery?
   ( ) Yes ( ) No If yes, please provide date and reason:_____
4. Have you ever been hospitalized
   ( ) Yes ( ) No If yes, please provide date and reason: _____
   _____
5. Do you take any medication?
   ( ) Yes ( ) No If yes, please list:_____
   Do you take any eye medication?
   ( ) Yes ( ) No If yes, please list: _____
6. Do you have any drug or food allergies?
   ( ) Yes ( ) No If yes, please list:_____

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Review of Systems	**Yes**	**No**	**If yes, explain**
Do you currently have any of the following problems:			
Chronic fever, unexpected weight loss/gain, fatigue	( )	( )	_____
Ear/nose/throat problems (hearing loss, sinus problems)	( )	( )	_____
Cardiovascular (chest pain ,irregular heart beat, high blood pressure)	( )	( )	_____
Respiratory problems(shortness of breath, coughing)	( )	( )	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)	( )	( )	_____
Urinary problems (pain or discomfort, blood in urine)	( )	( )	_____
Skin problems (rashes, excessive dryness)	( )	( )	_____
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	( )	( )	_____
Neurologic problems (numbness, weakness, headaches, paralysis)	( )	( )	_____
Psychiatric problems (depression, anxiety)	( )	( )	_____
Blood or lymphatic problems (anemia)	( )	( )	_____
Endocrine problems (diabetics, thyroid)	( )	( )	_____

7. Do any medical or eye diseases run in your family? (diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
   ( ) Yes ( ) No If yes, please explain_____

8. Do you smoke? If yes, how much _____ drink alcohol? _____ If yes, how much _____

9. If employed, how many hours per week do you work? _____
   Does your employment contribute to any stress in your life? Yes _____ No _____

Comments: _____

M.D. Signature :_____ Date:_____