SPECIALIZED EYE CARE

PATIENT HISTORY RECORD

Name _____ Referring Doctor _____ Today's Date _____

Date of Birth _____ Age _____ Sex (M/F) _____

Please answer the following questions about your medical history.

1. List any medical conditions for which you have been treated (i.e., diabetes, high blood pressure, arthritis).

   _____

2. Have you ever had any eye disease (i.e., glaucoma, cataract, "lazy" eye, retinal detachment)

   _____

3. List any past surgeries, including any eye surgery.

   _____

4. List any medications, including eye drops.

   _____

5. Do you have any prescription drug or food allergies? If yes, please describe.

   _____

6. Do your currently have any of the following problems? If yes, please circle.

Fatigue	Hearing Loss	Sinus Problems	Sore Throat	Irregular Heart Beat
Chest Pain	Shortness of Breath	Wheezing	Coughing	Heartburn
Diarrhea	Vomiting	Urinary Discomfort	Bloody Urine	Abdominal Pain
Skin Rashes	Excessive Dry Skin	Muscle Aches	Joint Pain	Swollen Joints
Headaches	Weakness	Depression	Numbness	Paralysis
Anxiety	Weight loss/gain	Others: (Please Specify)		

7. Do any medical or eye diseases run in your family (i.e., diabetes, glaucoma, macular degeneration)?

   _____

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

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

Comments

Doctor’s Signature Date