Complete form electronically and print before closing, or print blank form and complete manually. You will not be able to save the completed electronic form.

Print Form

# PATIENT HISTORY FORM

Patient's Name: _____ Birth Date: _____

Reason for your visit: _____ Visit Date: _____

*For office use only*
Reviewed
Physician Signature: _____ Date: _____

| PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL HISTORY: | YES | NO |
|---|---|---|
| Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis)? ***If Yes, please explain*** | ☐ | ☐ |
| Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)? ***If Yes, please explain*** | ☐ | ☐ |
| Have you had a recent radiology testing of your head (e.g., CT, MRI)? ***If Yes, you MUST bring the films or CD(s) to your visit*** | ☐ | ☐ |
| Have you ever had any surgery? ***If Yes, please provide date and reason*** | ☐ | ☐ |
| Have you ever been hospitalized? ***If Yes, please provide date and reason*** | ☐ | ☐ |
| Do you take any medications? ***If Yes, please list*** | ☐ | ☐ |
| Do you take any eye medications? ***If Yes, please list*** | ☐ | ☐ |
| Are you currently taking any blood thinners (Coumadin, warfarin, aspirin, baby aspirin, Plavix, clopidogrel, etc) or any herbal supplements? ***If so, please list in detail*** | ☐ | ☐ |
| Do you have any drug or food allergies? ***If Yes, please list*** | ☐ | ☐ |

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Print Form

# Patient History Form

Patient's Name: _____ Visit Date: _____

| Do You Currently Have Any Of The Following Problems: | Yes | No | If YES, Please Explain: |
|---|---|---|---|
| Chronic fever, unexpected weight loss/gain, fatigue | ☐ | ☐ | |
| Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat) | ☐ | ☐ | |
| Heart problems (e.g., chest pain, irregular heart beat) | ☐ | ☐ | |
| Respiratory problems (e.g., shortness of breath, wheezing, coughing) | ☐ | ☐ | |
| Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting) | ☐ | ☐ | |
| Urinary problems (e.g., pain or discomfort, blood in urine) | ☐ | ☐ | |
| Skin problems (e.g., rashes, excessive dryness) | ☐ | ☐ | |
| Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints) | ☐ | ☐ | |
| Neurologic problems (e.g., numbness, weakness, headaches, paralysis, vertigo) | ☐ | ☐ | |
| Psychiatric problems (e.g., depression, anxiety) | ☐ | ☐ | |
| Diabetes or other endocrinological disorders | ☐ | ☐ | |
| Anemia or other blood disorders | ☐ | ☐ | |

| Family And Social History: | Yes | No | If YES, Please Explain: |
|---|---|---|---|
| Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)? | ☐ | ☐ | |
| Do migraines run in your family? | ☐ | ☐ | |
| Do you currently smoke? If Yes, how much? | ☐ | ☐ | |
| Have you ever smoked? If Yes, indicate how much, how long, and when you stopped. | ☐ | ☐ | |
| Do you drink alcohol? If Yes, how much? | ☐ | ☐ | |
| Do you or have you ever used recreational drugs? | ☐ | ☐ | |