Patient History

Name _____ DOB _____ Gender: M / F Today's Date_____

(All major health insurers and Medicare now require us to obtain detailed medical history information. Also, many health problems and medications may affect your eyes or vision. Please fill out this form to the best of your ability and if you need help let us know.)

VISUAL SYMPTOMS (please check any problems you are currently having)

☐ Blur at Distance (driving)	☐ Itchy Eyes	☐ Eye Pain	☐ Glare/Halos
☐ Blur at Near (reading)	☐ Red Eyes	☐ Burning Eyes	☐ Seeing Floaters
☐ Difficulty Seeing at Night	☐ Watery Eyes	☐ Headaches	☐ Seeing Flashes
☐ Light Sensitivity	☐ Dry Eyes	☐ Double Vision	☐ Other _____

REVIEW OF SYSTEMS - do you have problems with any of the following (if yes please circle or list)

Yes	No	
☐	☐	**Eyes --** Glaucoma / Cataract / Lazy Eye / Retina Disease /_____
☐	☐	**Endocrine** – Diabetes /Thyroid Problems /_____
☐	☐	**Cardiovascular** – High Blood Pressure / High Cholesterol / Heart disease /_____
☐	☐	**Constitutional** – Fever / Weight Loss / Weight Gain /_____
☐	☐	**Ears, Nose, Throat, Mouth** – Sinus Problems / Sore Throat /_____
☐	☐	**Respiratory** – Cough / Asthma / Emphysema /_____
☐	☐	**Gastrointestinal** – Diarrhea / Reflux / Pain /_____
☐	☐	**Genitourinary** – Kidney Problems / Prostate Problems /_____
☐	☐	**Integumentary** – Skin Dryness / Rosacea /_____
☐	☐	**Musculoskeletal** – Arthritis / Joint Pain / Swollen Joints /_____
☐	☐	**Neurological** – Numbness / Headaches / Nausea / Multiple Sclerosis /_____
☐	☐	**Hematological/lymphatic** – Blood Disorders / Leukemia / Anemia /_____
☐	☐	**Allergic/Immunologic** – Hay Fever / Seasonal Allergies _____
☐	☐	**Psychiatric** – Depression / Anxiety / ADHD /_____
☐	☐	**Others** – Cancer _____
☐	☐	**Women –** Pregnant / Nursing /_____

PAST HISTORY – Please list past injuries or surgeries	**MEDICATIONS/VITAMINS** - Please list
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Family Physician Name:	**Medication Allergies:**

Yes	No		Yes	No	
☐	☐	Do wear sun glasses while outside and while driving?	☐	☐	Do you smoke?
☐	☐	Do you use a computer/smart phone?	☐	☐	Do you drink alcohol?
☐	☐	Are you interested in lenses that darken in the sun?	☐	☐	Do you use drugs?
☐	☐	Are you interested in wearing contact lenses?	Occupation:_____		
☐	☐	Are you interested in discussing LASIK?	Hobbies:_____		

FAMILY HISTORY – Do your family members have any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Glaucoma	☐	☐	Diabetic Retinopathy	☐	☐	Diabetes
☐	☐	Macular Degeneration	☐	☐	Retinal Detachment	☐	☐	High Blood Pressure
☐	☐	Cataracts	☐	☐	Blindness	☐	☐	Other _____

Dilation of the pupil is a common procedure used to better examine the inside of the eye. It allows us to detect and/or monitor conditions of the eye such as glaucoma and macular degeneration as well as diseases of the body such as diabetes and hypertension. Eye drops used to dilate your pupils last 4-6 hours. Light sensitivity and blurred vision, especially at near, are common. There are few risks to this procedure.

☐ **Yes, please perform a dilated exam** ☐ **No, I decline dilation today** ☐ **I want more information**

Patient's Signature: _____ Date_____

Patient Initial and date (subsequent visit): _____ _____ _____ _____

Doctor Use Only:

Date reviewed/changes noted: _____ _____ _____ _____ _____