



PATIENT HISTORY RECORD

Date: Referred By: Date of Birth:

Patient Name: Male Female Age:

Please answer the following questions about your medical status and history:

- 1. Have you ever been treated for any medical conditions (diabetes, high blood pressure, arthritis, etc.)?
2. Have you ever had any eye disease (glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
3. Have you ever had any surgery?
4. Have you ever been hospitalized?
5. Do you take any eye medications?
6. Do you have any drug or food allergies?
7. Have you ever had LASIK or refractive eye surgery?
8. Do you take any medications?

Are you currently experiencing any of the following: Yes No If YES, please explain:

Table with 4 columns: Condition, Yes, No, If YES, please explain. Rows include Chronic fever, Ear/nose/throat problems, Heart problems, Respiratory problems, Gastrointestinal problems, Urinary problems, Skin problems, Musculoskeletal problems, Neurologic problems, Psychiatric problems, Endocrine disease, Hematologic/Lymphatic, Immunologic.

Family and Social History

Do you have a family history of medical or eye diseases (diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

Yes No If YES, please explain:

Do you use tobacco? Yes No Drink alcohol? Yes No Do you drive? Yes No

Patient Signature: Date:

Provider Signature: Date: