

PATIENT HISTORY

Name: _____
 Date: _____

MEDICAL HISTORY

Allergies to medications, anesthetics, or other substances? _____

Yes No If yes, please list: _____

List all major illness, injury or surgery (sleep apnea, high BP, heart disease, etc): _____

List any medications you take: _____

Last medical exam: _____

Primary physician: _____
 Phone () _____

PERSONAL MEDICAL HISTORY

General	Yes	No	If yes, Explain
(Fever, Weight +/-)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat (Allergies/Cough)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (Asthma/Emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (Heart, vessels, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (ulcers, intestinal, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (rosacea, skin cancer)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/Immunologic (Rheumatoid Arthritis, Lupus, Hay Fever)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/Lymph (High Chol, Anemia, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine (Diabetes, Thyroid, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological (MS, Stroke, Seizures)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric (Anxiety, Depression)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Height _____			Weight _____

PERSONAL EYE HISTORY

	Yes	No	If yes, Explain
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gritty/Itchy/Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess Tearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infections of Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sties/Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	_____
Computer Strain	<input type="checkbox"/>	<input type="checkbox"/>	_____
LASIK Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Occupation _____

Birth order? 1st 2nd 3rd 4th 5th >5th

Do you use tobacco products? Yes No
 If yes... Type/Amt/How Long? _____

Do you drink alcohol? Yes No
 If yes... Type/Amt/How Long? _____

Do you use illegal drugs and or narcotics? Yes No
 If yes... Type/Amt/How Long? _____

Have you ever had a blood transfusion? Yes No

Have you ever been infected with:
 Gonorrhea Hepatitis HIV Syphilis TB None

FAMILY EYE HISTORY

	Yes	No
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Mac Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

FOR WOMEN ONLY

	Yes	No
Taking Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Nursing	<input type="checkbox"/>	<input type="checkbox"/>

RECREATION/HOBBIES

<input type="checkbox"/> Walking/Hiking	<input type="checkbox"/> Fishing/Boating	<input type="checkbox"/> Woodworking
<input type="checkbox"/> Biking	<input type="checkbox"/> Flying	<input type="checkbox"/> Painting
<input type="checkbox"/> Hunting	<input type="checkbox"/> Tennis/Racquetball	<input type="checkbox"/> Photography
<input type="checkbox"/> Camping	<input type="checkbox"/> Golf	<input type="checkbox"/> Gardening
<input type="checkbox"/> Travel	<input type="checkbox"/> Reading	<input type="checkbox"/> Sewing