Patient Health History

Patient Name:______________________________________ **DOB:**____/____/_______ **Date:**____/____/_______

Ocular History

Please circle any of the following eye conditions that you currently have or have been treated for in the past:

Glaucoma	Cataracts	Macular Degeneration	Eye Allergies	Blindness	Dry Eyes
Iritis	Styes	Diabetic Eye Disease	Retinal Detachment	Corneal Ulcers	
Eye Prosthesis					

Any eye injuries? Y / N Please explain.____

Medical History

Please list any medical conditions that you currently have or have had in the past:________________________

____

____

Current Weight:___________ Current Height:___________ Currently pregnant? Y / N

Systemic Surgical History

Please list any surgeries (not eye related)that you have had and the year it occurred:______________________

____

Family Medical History

Please note any family members (living or deceased) for the following:

Condition	Relationship to You	Condition	Relationship to You
Cancer	____________________	Kidney Disease	____________________
Diabetes	____________________	Lupus	____________________
Hypertension	____________________	Migraines	____________________
Heart Disease	____________________	Thyroid Disease	____________________

Ocular Surgical History

Have you ever had any eye surgeries? Y / N If Yes please list including which eye and year:____________________

____

Ocular Family History

Please note any family members (living or deceased) for the following:

Condition	Relationship to You	Condition	Relationship to You
Amblyopia (Lazy Eye)	____________________	Retinal Detachment	____________________
Cataracts	____________________	Retinitis Pigmentosa	____________________
Glaucoma	____________________	Strabismus	____________________
Keratoconus	____________________	Eye Tumor	____________________
Macular Degeneration	____________________	Unknown Vision Loss	____________________

Ocular Medications

Please list any eye medications you are currently taking (including over the counter):

____

____

Systemic Medications

Please list any non-eye medications you are currently taking (including over the counter):

____

____

Please complete back.

Therapeutic Side Effects/Allergies

Any side effects from previously taken medicines?____________________

Are you allergic to any specific medications? Y/N ____________________

Are you allergic to latex? Y/N

Social History (Please circle)

Tobacco Use: None Packs per day: <1 1-2 >2 Former Smoker Stopped When?__________

Alcohol Use: None Social Only 1-2 drinks per day Above average use Alcohol Dependence

Narcotic Use: None Recreational use Chemical Dependence

Sexually Transmitted Disease: None Yes HIV Positive

Spectacle Use History (Please circle)

Do you currently wear glasses? Y/N

What type? Single-vision Bifocal/Trifocal Progressive Computer

When were your glasses last updated?__________ Do you wear sunglasses? Y/N Are they prescription? Y/N

Do your glasses work well while using a computer? Y/N Do you have problems with glare? Y/N

Please explain any problems with your current glasses.____________________

____

Contact Lens History

Are you currently wearing contacts? Y/N

What name brand?____________________ Do you sleep in your contacts? Y/N

How many nights in a row?__________ How often do you replace your contacts?__________

What name brand of care solution do you use?____________________

Do you have up to date back up glasses? Y/N Do you wear sunglasses with your contacts? Y/N

Please explain any problems with your current contacts.____________________

____

If you have been unsuccessful with contacts in the past, please explain.____________________

____

Please use the space below to explain anything about your medical history that has not already been mentioned.

____

____

____

____

____

Please sign and date below.

____________________ ____________________

Patient or Guardian Date

Review of Systems

Patient Name:____ **DOB:**____/____/________ **Date:**____/____/_______

Do you currently have or have you ever had any problems in the following areas:

Allergy No / Yes Explain____
(examples: allergy to food, animals, environment, sinusitis)

Cardiovascular No / Yes Explain____
(examples: chest pain, angina, heart attack)

Constitutional No / Yes Explain____
(examples: weight gain/loss, appetite, excessive thirst/urination)

Endocrine No / Yes Explain____
(examples: thyroid, diabetes, elevated cholesterol)

Gastrointestinal No / Yes Explain____
(examples: reflux, ulcer, abdominal pain, colitis, hernia)

Genitourinary No / Yes Explain____
(examples: bladder infections, impotence, menopause, prostate)

Head No / Yes Explain____
(examples: headaches, ear infections, hearing loss, dental disorders)

Hematologic/Lymphatic No / Yes Explain____
(examples: anemia, breast cancer, leukemia, sickle cell)

Immunologic No / Yes Explain____
(examples: STDs, HIV Positive, Sjogren's, Tuberculosis)

Integumenary No / Yes Explain____
(examples: Acne, Dry Skin, Eczema, Psoriasis, Lupus, Sarcoid)

Musculoskeletal No / Yes Explain____
(examples: Arthritis, Muscular Dystrophy, Myasthenia, Gout)

Neurological No / Yes Explain____
(examples: brain tumors, headaches, MS, Cerebral Palsy, Epilepsy)

Psychiatric No / Yes Explain____
(examples: Autism, Bipolar Disorder, Depression, Dementia, Alzheimer's, Learning Disability)

Respiratory No / Yes Explain____
(examples: asthma, bronchitis, emphysema, COPD, lung cancer, TB)

Please sign and date below.

______________________________________ ______________________
Patient or Guardian Date