Patient History Form

Name:

Medical Doctor: ______________________

Eye History:

Date of Last Eye Exam: ______________________

Currently wear glasses? ______________________

Currently wear contact lenses? ______________________

Reason for Today's visit ______________________

____

____

Have you had or have been treated for any of the following? Circle all that apply.

Glaucoma	Cataract
Dry Eye	Injury
Nystagmus	Kerataconus
Strabismus	Amblyopia
Retina Detachment	Retinal Hole
Macular Degeneration	Eye Patching
Eye Surgery	Inflammatory eye disorder

Are you currently experiencing any of the following? Circle all that apply.

Blurry vision	Floaters
Burning	Halos
Discharge	Headaches
Double vision	Itching
Dryness	Light sensitivity
Excess tearing/watering	Light Flashes
Eye Pain/Soreness	Sandy or Gritty feeling

Family History:

Any family history of the following and whom?

Cancer ______________________

Diabetes Type 1 ______________________

Diabetes Type 2 ______________________

Hypertension ______________________

Hyperthyroid ______________________

Hypothyroid ______________________

Cataract ______________________

Macular Degeneration ______________________

Glaucoma ______________________

Current Height: ______________________

Current Weight: ______________________

Medical History:

Have you experienced or been treated for any of the following? *Circle all that apply*.

Development disabilities	Chrohn's
Cancer	Colitis
Fatigue syndrome	Ulcer
Hearing loss	Kidney Disease
Sinusitis	Prostate disease/cancer
Dry mouth	Herpes/Chlamydia
Laryngitis	Athritis
Multiple Sclerosis	Fibromyalgia
Epilepsy	Muscular Dystrophy
Cerebral Palsy	Ankylosing Spondylitis
Tumor	Osteoporosis
Migraine	Gout
Autism Spectrum Disorder	Eczema
Depression	Rosacea
ADD or ADHD	Psoriasis
Anxiety	Shingles
Bipolar Disorder	Anemia
Hypertension	Hypercholesteremia
Stroke	Environmental allergies
Chronic Heart failure	Rheumatoid Arthritis
Heart disease	Lupus
Vascular disease	Sjogrens Syndrome
Asthma	Do you or have you smoked? ______
Bronchitis	How much? ______
Emphysema	Do you drink? ______
Sleep Apnea	How much? ______

Current Medications: (prescription and over the counter)

____

____

____

____

____

Medication Allergies:

____

____

____