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PATIENT HISTORY

NAME____ DOB___________________
ADDRESS____
MEDICAL DR.__________________________________
PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS AND HISTORY:

1. HAVE YOU EVER BEEN TREATED FOR ANY MEDICAL CONDITIONS?
   YES NO IF YES, PLEASE EXPLAIN________________________________
2. HAVE YOU EVER HAD ANY EYE DISEASE?
   YES NO IF YES, PLEASE EXPLAIN________________________________
3. HAVE YOU EVER HAD ANY SURGERY?
   YES NO IF YES, PLEASE EXPLAIN________________________________
4. HAVE YOU EVER BEEN HOSPITALIZED?
   YES NO IF YES, PLEASE EXPLAIN________________________________
5. DO YOU TAKE ANY MEDICATIONS?
   YES NO IF YES, PLEASE LIST____________________________________
6. DO YOU HAVE ANY DRUG OR FOOD ALLERGIES?
   YES NO IF YES, PLEASE EXPLAIN________________________________

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING:
CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE……………………….YES/NO
EAR/NOSE/THROAT PROBLEMS………………………………………..…………………..YES/NO
HEART PROBLEMS…………………………………………………….…………………..YES/NO
RESPIRATORY PROBLEMS……………………………………………………………….YES/NO
GASTROINTESTINAL PROBLEMS……………………………………………………….YES/NO
URINARY PROBLEMS…………………………………………………………………..YES/NO
SKIN PROBLEMS…………………………………………………….…………………..YES/NO
MUSCULOSKELETAL PROBLEMS………………………………………………………YES/NO
NEUROLOGICAL PROBLEMS…………………………………………………………….YES/NO
PSYCHIATRIC PROBLEMS……………………………………………………………..YES/NO

FAMILY & SOCIAL HISTORY

DO ANY MEDICAL OR EYE DISEASES RUN IN YOUR FAMILY
(E.G., DIABETES, HIGH BLOOD PRESSURE, GLAUCOMA, CANCER)
YES NO IF YES, PLEASE EXPLAIN_______________________________________
____
____

DO YOU SMOKE? IF YES, HOW MUCH____
DO YOU DRINK ALCOHOL? IF YES, HOW MUCH____

M.D. SIGNATURE____ DATE_____________________