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PATIENT HISTORY RECORD

▲DATE (MM/DD/YY) ▲ REFERRED BY ▲ PRIMARY CARE PHYSICIAN ▲ BIRTH DATE ▲ AGE

▲PATIENTS NAME ▲ SEX ▲ SOC SEC NO.

▲ADDRESS ▲PHONE (H)

▲ EMPLOYER ▲ OCCUPATION ▲ PHONE(W)

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

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, asthma, cancer, cholesterol, thyroid, etc)

Yes ☐ No ☐ If YES, please explain:_____

2. Have you ever had any eye disease (e.g., glaucoma, cataract, "lazy" eye, retinal detachment, pterygium, macular degeneration)?

Yes ☐ No ☐ If YES, please explain:_____

3. Have you ever had any surgery:

Yes ☐ No ☐ If YES, please provide date and reason _____

4. Have you ever been hospitalized?

Yes ☐ No ☐ If YES, please provide date and reason _____

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 list:_____

7. Are you be pregnant? Please circle Yes of No

Review of Systems

Do you currently have any of the follow problems:	**Yes**	**No**	**If YES, please explain:**
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	_____
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (e.g. rashes, excessive dryness)	☐	☐	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurological problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (e.g., depression, anxiety)	☐	☐	_____

Family and Social History

Do any medical or eye diseases run in your family *(e.g., diabetes, high blood pressure, cancer, glaucoma, macular generation)*

Yes☐ No☐ If YES, please explain: _____

Do you smoke? If yes, how much? ☐ Drink alcohol? If yes, how much? ☐

If employed, how many hours per week do you work? ☐

▲ **Comments**

▲ **M.D. Signature** ▲ **Date**