PATIENT HISTORY RECORD

Patient Name _____ Date of Birth _____ Soc Sec. # _____

Primary Care Physician: _____

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, etc.)
   YES ( ) NO ( ) If yes, please explain:_____
2. Have you ever had any eye disease? (e.g., glaucoma, cataracts, wandering or "lazy" eye, retinal detachment, etc.)
   YES ( ) NO ( ) If yes, please explain:_____
3. Have you ever had any surgery?
   YES ( ) NO ( ) If yes, please provide date & reason:_____
   _____
4. Have you ever been hospitalized?
   YES ( ) NO ( ) If yes, please provide date & 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: _____
   _____

REVIEW OF SYMPTONS:

Do you have any of the following problems? If yes, please explain:

Chronic Fever, unexpected loss/gain of weight, fatigue..... YES ( ) NO ( ) _____
Ear/nose/throat problems? (hearing loss, sore throat).....YES ( ) NO ( ) _____
Heart problems? (chest pain, irregular heart beat)..... YES ( ) NO ( ) _____
Respiratory problems? (shortness of breath, coughing)..... YES ( ) NO ( ) _____
Gastrointestinal problems? (heartburn, vomiting)..... YES ( ) NO ( ) _____
Urinary problems? (pain, discomfort, blood in urine)..... YES ( ) NO ( ) _____
Skin problems? (rashes, excessive dryness)..... YES ( ) NO ( ) _____
Musculoskeletal problems? (muscles aches, joint pain)..... YES ( ) NO ( ) _____
Neurological problems? (numbness, headaches, paralysis)..YES ( ) NO ( ) _____
Psychiatric problems? (depression, anxiety)..... YES ( ) NO ( )_____

FAMILY AND SOCIAL HISTORY:

Do any medical or eye diseases run in your family? (diabetes, high blood pressure, cancer, glaucoma)
YES ( ) NO ( ) If yes, please explain:_____
_____

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

If employed, how many hours a week do you work?_____

Comments:_____

Doctor's Signature_____ Date_____