Patient History Form

NAME _____ **DATE** _____

What is the main reason for today's visit? _____ ☐ Routine eye exam

Are you currently experiencing any of these symptoms? Check all that apply:

☐ Blurred vision at distance
☐ Blurred vision at near
☐ Distorted vision
☐ Double vision
☐ Flashes of light
☐ Floaters or spots
☐ Fluctuating vision
☐ Loss of central vision
☐ Loss of side vision
☐ Burning
☐ Dryness
☐ Tearing (Epiphora)
☐ Eyelid swelling
☐ Eye pain or soreness
☐ Foreign body sensation
☐ Infection of eyelid
☐ Itching
☐ Mucous
☐ Drooping eyelid (Ptosis)
☐ Redness
☐ Sandy or gritty feeling
☐ Glare sensitivity
☐ Headaches
☐ Light sensitivity
☐ Tired eyes
☐ Other:

When was your last comprehensive eye exam? _____

When was your last physical exam (including blood work)? _____

DEMOGRAPHIC INFORMATION

Race
☐ Asian
☐ Black / African American
☐ Caucasian
☐ Native American
☐ Decline to specify
☐ Other:

Ethnicity
☐ Hispanic
☐ Non-Hispanic
☐ Decline to specify

Preferred language ☐ English ☐ Spanish ☐ Chinese ☐ Other:

MEDICAL HISTORY

Height _____ Weight _____ Primary Care Physician (PCP) _____

PCP Address _____ PCP Phone _____

CURRENT MEDICATIONS (INCLUDING EYE DROPS)	PURPOSE	DOSAGE	START DATE

☐ None

DRUG ALLERGIES	REACTION	OTHER ALLERGIES	REACTION

☐ None

Please continue on reverse →

PAST SURGERIES	DATE	SURGEON

☐ None

Do you or any of your blood relatives have a history of the following conditions? Check all that apply:

SELF	FAMILY		SELF	FAMILY	
☐	☐	Amblyopia (lazy eye)	☐	☐	Constitutional (fever, weight loss, etc.)
☐	☐	Blindness	☐	☐	Ears, Nose, Throat
☐	☐	Cataract	☐	☐	Cardiovascular (heart disease, high blood pressure)
☐	☐	Color blindness	☐	☐	Respiratory (asthma, emphysema, etc.)
☐	☐	Diabetic retinopathy	☐	☐	Gastrointestinal
☐	☐	Dry eye syndrome	☐	☐	Genital, Kidney, Bladder
☐	☐	Eye injuries	☐	☐	Muscles, Bones, Joints (arthritis, etc.)
☐	☐	Glaucoma	☐	☐	Skin (acne, skin cancer, etc.)
☐	☐	Glaucoma suspect	☐	☐	Neurological (multiple sclerosis, Parkinson's, etc.)
☐	☐	Macular degeneration	☐	☐	Psychiatric (ADHD, anxiety, depression, etc.)
☐	☐	Retinal detachment	☐	☐	Endocrine (diabetes, hypothyroid, etc.)
☐	☐	Strabismus (eye turn)	☐	☐	Blood / Lymph (anemia, high cholesterol, etc.)
☐	☐	Other:	☐	☐	Allergic / Immunologic (seasonal allergies, lupus, etc.)

Are you currently pregnant or nursing? No Yes

SOCIAL HISTORY

What is your occupation? _____ Years _____ Employer _____

Do you drink alcohol?	No	Occasional	1 / day	2-3 / day	4+ / day
Do you smoke?	No	Occasional	½ pack / day	1 pack / day	1+ pack / day
Past smoker?	No	Yes, quit _____			
Do you chew tobacco?	No	Yes			
Do you use nutritional supplements?	No	Yes			
Do you engage in regular exercise?	No	Yes			
Do you currently wear glasses?	No	Yes	☐ Full-time		
			☐ Part-time for:	Driving	Reading Computer
Do you currently wear contact lenses?	No	Yes			

How many hours a day do you spend on the computer? _____ Distance from screen _____

What are your hobbies? _____

What sports do you participate in? _____