PATIENT HISTORY:

Name: ____ Birthdate: ______________________

GENERAL HISTORY:	REVIEW OF SYSTEMS:	EYES:
☐ Arthritis	☐ Anemia	☐ Blurred Vision
☐ Asthma	☐ Anxiety/Depression	☐ Burning
☐ Cancer	☐ Cough	☐ Discharge
☐ Diabetes	☐ Dry Mouth	☐ Double Vision
☐ Heart Disease	☐ Ear Ache	☐ Drooping Eyelid
☐ Hepatitis	☐ Fever	☐ Dryness
☐ High Blood Pressure	☐ Increase in Blood Pressure	☐ Eye Pain
☐ High Cholesterol	☐ Migraine/Headaches	☐ Flashes of Light
☐ Kidney Disease	☐ Numbness	☐ Floaters
☐ HIV/Syphilis	☐ Racing Pulse	☐ Foreign Body Sensation
☐ Lung Disease	☐ Skin Growths/Rash	☐ Itchiness
☐ Migraine/Headaches	☐ Stuffy Nose	☐ Light Sensitivity
☐ Stroke	☐ Swelling/Hives	☐ Loss of Vision
☐ Thyroid	☐ Upset stomach/Constipation	☐ Redness
☐ Tuberculosis	☐ Weight Loss	☐ Tearing/Watering
☐ Other: _____________	☐ Other: _____________	☐ Other: ____________

FAMILY HISTORY: ☐ Arthritis ☐ Blindness ☐ Cancer ☐ Cataracts ☐ Diabetes ☐ Glaucoma ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Lupus ☐ Stroke ☐ Thyroid ☐ Other: _____________

•LIST ANY GENERAL AND EYE SURGERIES (Including the year and which eye.):___________________________
____

•MEDICATIONS (Please provide the name and dose of any medication you are currently taking OR attach list.): ____

•ARE YOU ALLERGIC TO ANY MEDICATIONS? ____

•ARE YOU ALLERGIC TO LATEX? Y N

•ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING? (Circle if applicable.) Y N

•DO YOU SMOKE? Y N Occasionally •DO YOU DRINK ALCOHOL? Y N Occasionally

Patient or Guardian Signature ___________________________________ **Date** _________________

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