

Patient History Record

Date Technician Obtained _____
Technician _____

Name: _____ DOB: _____ Allergies/Intolerances
____ NKDA ____ PCN ____ Sulfa
____ Iodine (lobster/shrimp)

Referring Doctor: _____ Eye Doctor: _____
Primary Doctor: _____ Endocrine: _____
Where did you buy your glasses? _____ Cardiologist: _____
Other: _____

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, lupus, sarcois)?
YES ___ NO ___, if YES, please explain: _____
2. If you have diabetes, do you have any complications?
Impotence: YES ___ NO ___ Foot Disease: YES ___ NO ___ Kidney Disease: YES ___ NO ___ Eye Disease: YES ___ NO ___
3. Have you ever had any infections? Tuberculosis: YES ___ NO ___ Hepatitis: YES ___ NO ___ HIV: YES ___ NO ___
Syphilis: YES ___ NO ___ Herpes: YES ___ NO ___
4. Have you ever had any surgery?
YES ___ NO ___, if YES, please provide date and reason: _____
5. What year were you diagnosed with: Diabetes: _____ Hypertension: _____
6. Have you ever been hospitalized?
YES ___ NO ___, if YES, please provide date and reason: _____
7. Do you take insulin? YES ___ NO ___
8. Do you take other medications? YES ___ NO ___ List on reverse side of sheet
9. Do you take any eye medications? YES ___ NO ___ If YES, please list: _____

10. Have you ever had any eye problems?

| | Right | Left | When | | Right | Left | When |
|---------------------------|-------|------|------|----------------------|-------|------|------|
| Cataract Surgery | ___ | ___ | ___ | Macular Degeneration | ___ | ___ | ___ |
| Glaucoma | ___ | ___ | ___ | Diabetic Retinopathy | ___ | ___ | ___ |
| Retina (surgery/laser) | ___ | ___ | ___ | Amblyopia (lazy eye) | ___ | ___ | ___ |

Review of Symptoms

Do you currently have any of the following 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, heart attack) | ___ | ___ | ___ |
| 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) | ___ | ___ | ___ |
| Neurologic problems (e.g., numbness, weakness, headaches, paralysis, stroke) | ___ | ___ | ___ |
| Psychiatric problems (e.g., depression, anxiety) | ___ | ___ | ___ |

Family and Social History

Do any medical or eye disease run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

YES ___ NO ___, if YES, please explain: _____

Do you smoke? _____ Do you drink alcohol? _____
YES ___ NO ___, if YES, how much? _____ YES ___ NO ___, if YES, how much? _____
History of Drug Abuse _____ When _____ Where _____
If employed, how many hours per week do you work? _____ Occupation: _____

MEDICATIONS

| | | |
|----|----|-----|
| 1. | 5. | 9. |
| 2. | 6. | 10. |
| 3. | 7. | 11. |
| 4. | 8. | 12. |

SURGERIES

| | | |
|----|----|-----|
| 1. | 5. | 9. |
| 2. | 6. | 10. |
| 3. | 7. | 11. |
| 4. | 8. | 12. |