PATIENT MEDICAL HISTORY RECORD

PATIENT'S NAME SEX AGE

EYE HISTORY

Thank you for choosing our office for your eye care. To better serve you, please answer the following questions:

1. Do you wear glasses? **yes** _____ **no** _____
2. Do you wear contact lenses? **yes** _____ **no** _____
3. Do you have problems reading? **yes** _____ **no** _____
4. Are you currently experiencing any eye symptoms? Please circle all that apply:

   Eye Pain Blurred Vision Eyelid Crusting Flashes of light Halos Floaters

   Discharge Light Sensitivity Double Vision Decreased Vision

5. Have you ever had an eye injury? Please describe: _____
6. Have you ever had eye surgery? Please list type, which eye, and approximate dates:
   _____

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, cataract, wandering, or "lazy" eye, retinal detachment)?
   _____**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: _____
   _____

   Do you use any eye medications? _____**YES** _____**NO** IF **YES**, please list: _____
6. Do you have any drug or food allergies? _____**YES** _____**NO** IF **YES**, please list: _____
   _____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, or macular degeneration)? _____**YES** _____**NO** IF **YES**, please explain: _____
_____

Do you smoke? _____**YES** _____**NO** IF **YES**, how much? _____

Do you drink alcohol? _____**YES** _____**NO** IF **YES**, how much? _____

Do you or have you ever used recreational drugs? _____**YES** _____**NO** IF **YES**, type and when: _____

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

_____ _____

Signature Date

11/18