

PATIENT HISTORY RECORD

BIRTHDATE	NAME	DATE
EMPLOYER	OCCUPATION	PHONE (W)
REFERRED BY	PRIMARY CARE PHYSICIAN	

Please answer the following questions about your medical status and history.

- Please circle any of the following medical problems you have or have been treated for:
High blood pressure Blood problems Kidney Disease Stroke
Stomach Ulcers Heart disease Tuberculosis Lupus
Rheumatoid arthritis Lung disease Liver disease Cancer
Sinus infections Skin disorders Thyroid disease Other _____
Diabetes: How Long? _____ Physician treating your diabetes _____
- Have you ever had any eye disease: (e.g. glaucoma, cataract, answering or "lazy eye", retinal detachment)?
Yes No If YES, please describe _____
- Have you ever had eye surgery?
Yes No If YES, please describe _____
- Do you take any medications?
Yes No If YES, please describe _____
- Do you take any eye medications?
Yes No If YES, please describe _____
- Do you have any drug or food allergies?
Yes No If YES, please describe _____

Review of Systems

Do you currently have any of the following problems?	YES	NO	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/Nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems(e.g. heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems(e.g. muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological problems (e.g. numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g. depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____

- Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
YES NO If YES, please describe: _____
- Do you smoke? If YES, how much? _____ Drink alcohol? If YES, how much? _____

MD comments

MD Signature

Date

