PATIENT HEALTH HISTORY

Patient's Name:	Date:

Date of **birth**:	Date of last **physical exam:**	Date of last **eye exam:**

List all medications you currently take (prescription and over-the-counter):

Do you have known **allergies** to any medications? **YES** **NO** If YES please list:

List all **eye diseases** (glaucoma, diabetic retinopathy, cataracts, etc.) or **eye injuries** (car accidents, metal in the eye, etc.):

List any **surgeries** you have had (cataract, tonsillectomy, appenedectomy, etc.):

Do you **currently** have any problems in the following areas?

EYES	**YES**	**NO**	**EYES**	**YES**	**NO**
Loss of vision			Itching		
Blurred vision			Burning		
Fluctuating vision			Foreign Body Sensation		
Distorted vision			Glare (halos) or light sensitivity		
Loss of side vision			Excess tearing or watering		
Double vision			Eye pain or soreness		
Tired eyes			Infection of eye or eyelid		
Crossed eye, lazy eye			Mucous discharge		
Drooping eye lid			Dryness		
Floaters			Sandy or gritty feeling		
Flashes of Lights			Redness		

If this examination is for a school age child please answer the following questions:

	YES	**NO**
Does your child complain of headaches at school?		
Does your child lose his/her place while reading?		
Do words run together when your child reads?		
Does your child report eye strain when reading?		
Has an involuntary eye turn been observed?		

Please turn over and complete the other side

History reviewed (For doctor use only)

*Dr.'s Signature*______________________*Date*___/____/____ *Dr.'s Signature*______________________*Date*___/____/____
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Check **all medical conditions** that apply to you. Please circle or explain the condition in each category.

	YES	NO	Explain:
ALLERGIC/IMMUNOLOGIC (drug allergy, environmental allergy, rheumatoid arthritis, lupus, other)			
MUSCULOSKELETAL (fibromyalgia, muscular dystrophy, osteoarthritis, ankylosing spondylitis, other)			
CARDIOVASCULAR (heart disease, hypertension, stroke, vascular disease, other)			
GASTROINTESTINAL (Crohn's disease, colitis, stomach ulcer, digestive problems, other)			
NEUROLOGICAL (multiple sclerosis, epilepsy, Alzheimer's, Parkinson's, cerbrovascular, other)			
CONSTITUTIONAL SYMPTOMS (developmental disability, weight loss, fever, fatigue, trauma, other)			
GENITOURINARY(STD, kidney disease, other)			
PSYCHIATRIC (depression, panic disorder, schizophrenia, other)			
EARS, NOSE, THROAT (upper resp. tract infection, ear ache, runny nose, sore throat, ringing/tinitis, other)			
HEMATOLOGIC/LYMPH (anemia, large volume blood loss, leukemia, high cholesterol, other)			
RESPIRATORY (asthma, bronchitis, emphysema, other)			
ENDOCRINE (diabetes: insulin or non-insulin dependent, thyroid disease, hormonal dysfunction, other)			
SKIN (eczema, rosacea, psoriasis, other)			

FAMILY HISTORY: Does anyone in your family have the following conditions?

DISEASE	YES	NO	**Relationship to patient**: M=Mother, F=Father, B=Brother, S=Sister, GM=Grandmother, GF=Grandfather
Blindness			
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Diabetes			
Heart disease			
High Blood pressure			
Cancer			
Stroke			
Other			

SOCIAL HISTORY: Answer only if pertinent to you.

Do you smoke? **YES NO** If YES, how much: occasional ½ pack/day 1 pack/day 1+ pack/day If YES, how long have you smoked?_____ If stopped, how long did you smoke?_____
Do you drink alcohol? **YES NO** If YES, how much: occasional 1/day 2-3/day 4+/day
Do you have problems with glare at night? **YES NO**
Have you ever tried contact lenses? **YES NO**
Do you currently wear contact lenses? **YES NO** If YES, when did you start?
Do you currently wear glasses? **YES NO** If YES, how old is your current pair?
Are you interested in LASIK? **YES NO**
Do you drive? **YES NO** If yes, do you have visual difficulty with driving? **YES NO**
Females only: Are you pregnant? **YES NO** Breastfeeding? **YES NO**