

Patient History Form

Patient Name _____

Date _____

Birth Date _____

Referred by _____

REVIEW OF SYSTEMS
Do you currently have any of the following problems?

If YES, please explain.

1. Please list medication you are taking, including eye drops.		
2. Do you have any allergies to any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Constitutional (fever, weight loss, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Eyes (glaucoma, cataract, lazy eye, retina problems, other - please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Ear / nose / mouth / throat (hearing loss, sinus problems, sore throat)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Cardiovascular (heart problems, chest pain, irregular heart beat)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Respiratory (asthma, shortness of breath, wheezing, coughing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Gastrointestinal (heartburn, abd. pain, diarrhea, vomiting)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Genitourinary (urinary problems, blood in urine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Integumentary (skin rashes, excessive dryness)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Musculoskeletal (muscle aches, joint pain, swollen joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Neurological (numbness, weakness, headaches, paralysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Hematologic/Lymphatic (blood disorders, leukemia)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Allergic/Immunologic (hay fever, allergies)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Endocrine (thyroid problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Psychiatric (depression, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Family and social history: Do any medical or eye diseases run in your family. If YES, Please note relationship to patient.

- Glaucoma _____
- Diabetes _____
- High blood pressure _____
- Macular degeneration _____
- Other _____

Do you smoke? If YES, how much? Yes No

How much: _____

Drink alcohol? If YES, how much? Yes No

How much: _____

Comments: _____

Physician's Signature: _____

Date: _____