PATIENT HISTORY RECORD

ACCT # _____

DATE (MM / DD / YY)	REFERRED BY	BIRTHDATE	
PATIENT'S NAME		SEX	AGE
ADDRESS		PHONE (H)	
EMPLOYER	OCCUPATION	PHONE (W)	
SOC. SEC. NO.	PRIMARY CARE PHYSICIAN		

Past Medical and Surgical 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, macular degeneration)?
   Yes ☐ No ☐ If YES, please explain: _____
3. Have you ever had any surgery (including eye 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 take any eye medications?
   Yes ☐ No ☐ If YES, please list: _____

   Do you have any drug or food allergies?
   Yes ☐ No ☐ If YES, please list: _____
   _____

Review of Symptoms	**Yes**	**No**	**If Yes, please explain:**
Do you currently have any of the following problems:			
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)	☐	☐	_____
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)	☐	☐	_____
Neurological problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (e.g., depression, anxiety)	☐	☐	_____

Family History

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 explain: _____

_____

Social History

Do you smoke? If yes, how much? _____ Drink alcohol? If yes, how much? _____ Prior drug use _____

Marital Status ☐ Married ☐ Divorced ☐ Widowed ☐ Single Occupation: _____

Do you live ☐ Alone ☐ With spouse ☐ Other _____

I AUTHORIZE YOU TO GIVE ME REASONABLE AND PROPER MEDICAL CARE BY TODAY'S STANDARDS

_____

▲ Patient Signature ▲ Date

_____

▲ M.D. Signature ▲ Date