PATIENT HISTORY RECORD ACCT # _____

DATE	PATIENT'S NAME	BIRTHDATE	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 eye surgery)? Yes ☐ No ☐
   If YES, please provide date and reason _____

4. 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: _____

5. If female, are you currently pregnant? Yes ☐ No ☐ Males NA ☐
6. If female, are you currently nursing? Yes ☐ No ☐ Males NA ☐

Family History

Do any eye diseases run in your family (e.g., glaucoma, macular degeneration) Yes ☐ No ☐

If YES, please explain: _____

Social History

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

Drink alcohol? Yes ☐ No ☐ If YES, how much? _____

Prior drug use? Yes ☐ No ☐ If YES, please explain: _____

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