

PATIENT HISTORY RECORD

NAME: _____ DATE OF

BIRTH: _____

RETAIL PHARMACY:

Name: _____ Phone: _____

Address: _____

MAIL ORDER PHARMACY:

Name: _____ Phone: _____

Address: _____

MEDICAL HISTORY

Please answer the following questions:

1. Have you ever been treated for any medical conditions?

- NO Diabetes (circle: Type 1 / Type 2) High blood pressure High cholesterol
 Cardiovascular disease Cancer Thyroid Other: Please list: _____

If diabetic: Date of diagnosis: _____ Self monitoring? YES NO

Blood sugar: _____ Date: _____ HbA1C: _____ Date: _____

2. Have you ever had any eye diseases?

- NO Cataracts Glaucoma Macular degeneration Retinal detachment Injury
 Eye turn Amblyopia Dry eye Other: Please list: _____

3. Have you ever had any eye surgeries?

- NO Cataract: date: _____ Refractive (circle: LASIK / PRK / RK) date: _____
 Laser: type/date: _____ Injection: type/date: _____
 Other: Please list: _____

4. Have you ever had any other surgeries?

- NO YES Please list: _____

5. Have you ever been hospitalized?

- NO YES Reason: _____

6. Do you use any eye medications?

- NO YES Please list: _____

7. Please list all medications (pills or injections) you routinely use, including vitamins/supplements:

8. Do you have any seasonal, drug, or food allergies?

- NO YES Please list: _____

SOCIAL HISTORY

Do you smoke? NO YES; how much? _____

Do you drink alcohol? NO YES; how much? _____

Hobbies: Computer Sewing Reading Other: _____

FAMILY HISTORY

Do any medical conditions run in your family?

- NO Diabetes (circle: Type 1 / Type 2) High blood pressure High cholesterol
 Cardiovascular disease Cancer Thyroid Other: Please list: _____

Do any eye conditions run in your family?

- NO Cataracts Glaucoma Macular degeneration Retinal detachment Injury
 Eye turn Amblyopia Other: Please list: _____

REVIEW OF SYSTEMS

Do you have any of the following problems?:

- Chronic fever, unexpected weight gain/loss, fatigue, night sweats?
 NO YES Please explain _____
- Ear, nose or throat problems?
 NO YES Please explain _____
- Heart problems?(irregular heartbeat, chest pain)
 NO YES Please explain _____
- Respiratory problems? (shortness of breath, wheezing, coughing)
 NO YES Please explain _____
- Gastrointestinal problems? (heartburn, abdominal pain)
 NO YES Please explain _____
- Urinary problems? (pain or discomfort, blood in urine)
 NO YES Please explain _____
- Skin problems?(rashes, excessive dryness)
 NO YES Please explain _____
- Musculoskeletal problems? (muscle aches, joint pain)
 NO YES Please explain _____
- Neurological problems? (numbness, weakness, headaches, dizziness)
 NO YES Please explain _____
- Psychiatric problems? (depression, anxiety)
 NO YES Please explain _____
- Other? Please list/explain: _____

→ ☺ **PATIENT'S SIGNATURE** _____ **DATE** _____
DOCTOR'S SIGNATURE _____ REVIEW DATE _____
DOCTOR'S SIGNATURE _____ REVIEW DATE _____
DOCTOR'S SIGNATURE _____ REVIEW DATE _____