# Patient History Form

Date ___________________

Last name ___________________________ First name ____________________ DOB __________________

Address _____________________________________ City ________________ State ______ Zip ________

Best contact number (_______)_______________ Alternative contact number (_______)_______________

Email _________________________________ Date of last eye exam ___________________

Emergency contact: Name ______________________________ Relation _____________________

Phone number (________)________________

## Medical Information

Do you have problems with any of these systems? (Please circle yes or no)

| | | | |
|---|---|---|---|
| Diabetic | Yes/No | Muscles/bones | Yes/No |
| High Blood Pressure | Yes/No | Skin | Yes/No |
| Headaches | Yes/No | Endocrine (glands) | Yes/No |
| Ears/Nose/Throat | Yes/No | Blood/lymph | Yes/No |
| Cardiovascular | Yes/No | Immunological | Yes/No |
| Respiratory | Yes/No | Gastrointestinal | Yes/No |
| Nervous | Yes/No | Urinary | Yes/No |

Other health problems _________________________________________________________________________

Current medications: ___________________________________________________________________________

Are you allergic to any medications? Yes/No If yes, list ____________________________________________

Have you had any operations? Yes/No If yes, list ________________________________________________

Primary care doctor: Name ____________________________ Phone number (________)________________

## Family History

| | | | | | |
|---|---|---|---|---|---|
| High Blood Pressure | Yes/No | Relation _________ | Macular Degeneration | Yes/No | Relation ________ |
| Diabetes | Yes/No | Relation _________ | Cataracts | Yes/No | Relation ________ |
| Glaucoma | Yes/No | Relation _________ | Retinal Detachment | Yes/No | Relation ________ |

## Personal Eye Information

Are you having any vision problems? Yes/No If yes, explain ______________________________________

Have you had any eye operations? Yes/No Type __________________________ Date ________________

Have you had an eye injury? Yes/No Type __________________________ Date ________________

Do you have any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Glaucoma | Yes/No | Retinal Detachment | Yes/No | Lazy Eye | Yes/No |
| Macular Degeneration | Yes/No | Dry Eyes | Yes/No | Pain/Discomfort | Yes/No |
| Cataracts | Yes/No | | | | |

Do you wear: Glasses? Yes/No Contacts? Yes/No If yes, type _________________________________