Clear Form

PATIENT HISTORY RECORD

Print Form

DATE_____PATIENT'S NAME_____DATE OF BIRTH_____AGE_____

SEX_____ADDRESS_____CITY_____STATE_____ZIP_____

OCCUPATION_____EMPLOYER_____WORK PHONE_____

HOME PHONE_____CELL PHONE_____

PRIMARY CARE PHYSICIAN _____PHONE_____

PAST MEDICAL HISTORY

Please answer the following questions about your medical status and history:

1. Have you ever been treated for a medical condition, such as diabetes, high blood pressure, arthritis, etc.? No ☐ Yes ☐

Please explain_____

2. Have you had any eye disease, such as glaucoma, cataract, lazy eye, etc? No ☐ Yes ☐ Please explain: _____

_____

3. Have you had any surgery within the last 10 years? No ☐ Yes ☐ Please explain: _____

_____

4. Have you ever been hospitalized more than a day? No ☐ Yes ☐ Please list: _____

_____

5. Do you take any medication? No ☐ Yes ☐ Please list: _____

_____

_____

6. Do you take any eye medication? No ☐ Yes ☐ Please list: _____

_____

7. Do you have any drug or food allergies? No ☐ Yes ☐ Please list: _____

_____

REVIEW OF SYSTEMS

Do you currently have any of the following problems?	**No**	**Yes**	**Please explain:**
Chronic fever, weight lost/gain, fatigue……	☐	☐	_____
Ear/nose/throat problems……	☐	☐	_____
Heart problems chest pain, irregular heart beat……	☐	☐	_____
Respiratory problems, wheezing, coughing……	☐	☐	_____
Gastrointestinal problems, heartburn, diarrhea……	☐	☐	_____
Urinary Problems, discomfort, blood in urine……..	☐	☐	_____
Skin problems, rash, excessive dryness.....	☐	☐	_____
Joint muscle pain, aching or swelling……...	☐	☐	_____
Neurological problems, numbness, weakness……	☐	☐	_____
Psychiatric problems, depression, anxiety.....	☐	☐	_____
Hematalogic/lymphatic……..……	☐	☐	_____
Endocrine……..……..	☐	☐	_____

FAMILY AND SOCIAL HISTORY

Do any medical or eye disease run in your family, such as diabetes, high blood pressure, glaucoma? No ☐ Yes ☐

Please explain:_____

Do you smoke? No ☐ Yes ☐ How Much?_____ Do you drink alcohol? No ☐ Yes ☐ How much? _____

Comments_____

DATE	DR.	DATE	DR.	DATE	DR.	DATE	DR.	DATE	DR.