

PATIENT HISTORY RECORD

Patient Name _____

Date _____

EYE HISTORY

1. What is the main problem that you are having with your eyes? _____

2. Have you ever been diagnosed with any of the following eye diseases?

- Cataracts Glaucoma Retinal Detachment Dry Eyes
 Iritis Macular Degeneration Crossed/Lazy Eye

3. Have you had previous eye surgery or laser surgery? Yes No If yes, please list: _____

4. Do you use any eye drops? Prescription Over the counter None
If yes, please list: _____

5. Do you wear Glasses Contact Lenses? How old are they? _____

REVIEW OF SYSTEMS

Yes No If Yes, please explain:

1. Do you currently have any of the following problems?

- | | | |
|--|--------------------------|-------|
| Diabetes | <input type="checkbox"/> | _____ |
| High Blood Pressure | <input type="checkbox"/> | _____ |
| Heart (chest pain, irregular heart beat) | <input type="checkbox"/> | _____ |
| Stroke or TIA | <input type="checkbox"/> | _____ |
| Black-out Spells | <input type="checkbox"/> | _____ |
| Kidney Disease (dialysis, kidney stones) | <input type="checkbox"/> | _____ |
| Liver Disease | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | _____ |
| Ear/nose/throat (hearing loss, sinus problems) | <input type="checkbox"/> | _____ |
| Respiratory or Lung (shortness of breath) | <input type="checkbox"/> | _____ |
| Asthma | <input type="checkbox"/> | _____ |
| Oxygen Use | <input type="checkbox"/> | _____ |
| Thyroid | <input type="checkbox"/> | _____ |
| Bleeding Disorders | <input type="checkbox"/> | _____ |
| Gastrointestinal (heartburn, abdominal pain, diarrhea) | <input type="checkbox"/> | _____ |
| Urinary (pain or discomfort, blood in urine) | <input type="checkbox"/> | _____ |
| Skin (rashes, excessive dryness) | <input type="checkbox"/> | _____ |
| Musculoskeletal (muscle aches, joint pain) | <input type="checkbox"/> | _____ |
| Neurologic (numbness, weakness, headaches, paralysis) | <input type="checkbox"/> | _____ |
| Psychiatric (depression, anxiety) | <input type="checkbox"/> | _____ |
| Communicable Disease (i.e. Hepatitis) | <input type="checkbox"/> | _____ |

2. List any previous surgeries you may have had: _____

3. Have you had any past anesthesia reaction? Yes No If yes, please explain: _____

REVIEW OF SYSTEMS (Continued)

4. List the medications you take, if any: _____

5. Do you have any drug or food allergies? Yes No If yes, please list: _____

FAMILY AND SOCIAL HISTORY

1. Do you have any family members who have been treated with any of the following? If yes, please state relationship.

Glaucoma _____ Retinal Detachment _____
 Macular Degeneration _____ Blindness _____

2. Do you smoke? Yes No If yes, how much? _____

3. Do you drink alcohol? Yes No Social

Additional Comments: _____

Physician Signature _____ Date _____

Updated with patient Yes No Date _____

In case of necessary eye surgery, I authorize my medical information given on this form to be released to the surgery center.

Patient Signature _____ Date _____