AFFILIATED EYE SURGEONS
PATIENT HISTORY RECORD

Patient Name: _____ Date: _____
Primary Care Physician: _____
Referring /Specialty Dr._____

Preferred Pharmacy: _____Phone #: _____
Pharmacy Location: _____

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

Medical History- Current and / or Past:

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation (IrregularHeartbeat)
- ❑ Bone Marrow Transplantation
- ❑ BPH
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV / AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke

Other: _____
_____
_____

Surgical History:

- ❑ Appendix (Appendectomy)
- ❑ Bladder (Cystectomy)
- ❑ Breast : Breast Biopsy
- ❑ Breast : Lumpectomy (Left Breast)
- ❑ Breast : Lumpectomy (Right Breast)
- ❑ Breast : Mastectomy (Left Breast)
- ❑ Breast : Mastectomy (Right Breast)
- ❑ Colon (Colectomy) : Colon Cancer
- ❑ Colon: Colostomy
- ❑ Gallbladder (Cholecystectomy)
- ❑ Heart : Biological Valve Replacement
- ❑ Heart : Coronary Artery Bypass Surgery
- ❑ Heart : PTCA
- ❑ Joint Replacement : Hip (Left)
- ❑ Joint Replacement : Hip (Right)
- ❑ Joint Replacement : Knee (Left)
- ❑ Joint Replacement : Knee (Right)
- ❑ Kidney : Kidney Stone Removal
- ❑ Kidney : Kidney Transplant
- ❑ Prostate (Prostatectomy)
- ❑ Skin : Melanoma
- ❑ Skin : Skin Biopsy
- ❑ Spleen (Splenectomy)
- ❑ Uterus (Hysterectomy) : Fibroids
- ❑ Uterus (Hysterectomy) : Uterine Cancer
- ❑ Uterus (Hysterectomy): Cervical Cancer

Other: _____

Any problems from anesthesia? ☐ yes ☐ no If yes, please explain

_____

_____

_____

Ocular History- Current and / or Past:

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract Right Eye
- ☐ Cataract Left Eye
- ☐ Contact Lenses
- ☐ Corneal Dystrophy
- ☐ Diabetic Retinopathy
- ☐ Dry Eyes
- ☐ Glasses
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Macular Epiretinal Membrane
- ☐ Narrow Angles
- ☐ Ocular Hypertension
- ☐ Ophthalmic Migraine
- ☐ Pseudoexfoliation
- ☐ Retinal Tear
- ☐ Strabismus (Lazy Eye)
- ☐ Posterior Vitreous Detachment
- ☐ Vitreous Floaters

Other: _____

_____

_____

Ocular Surgery- Past:

- ☐ Blepharoplasty
- ☐ Cataract Surgery
- ☐ Corneal Transplant
- ☐ LASIK
- ☐ PRK
- ☐ PTOSIS Repair
- ☐ Punctal Plugs
- ☐ Strabismus Surgery
- ☐ Trabeculectomy (Glaucoma)
- ☐ Yag Capsulotomy

Other: _____

_____

_____

Eye Drops (Prescription and Over the Counter):

_____

_____

_____

List the Medications you take:

Name	Dosage	Frequency	Purpose

Do you have any DRUG or FOOD ALERGIES? ❑ yes ❑ no If yes, please list *INCLUDING WHAT REACTION YOU HAD:*

_____

_____

_____

Social History: (Please mark all that apply)

Smoking:

- ❑ Current every day smoker
- ❑ Current some day smoker
- ❑ Former smoker
- ❑ Never smoked
- ❑ Smokeless tobacco

Alcohol Use:

- ❑ None
- ❑ Less than 1 drink per day
- ❑ 1-2 drinks per day
- ❑ 3 or more drinks per day
- ❑ **Former Drinker**

Driving Status:

- ❑ Drives in the daytime
- ❑ Drives at night

Drug Use:

- ❑ IV Drug use
- ❑ Drug Use

Safety:

- ❑ Patient feels safe at home
- ❑ Patient feels unsafe at home

Exercise:

- ❑ Never
- ❑ A few times a month

Family History: REQUIRED TO STATE RELATIONSHIP

- ❑ Blindness _____
- ❑ Cancer _____
- ❑ Cataracts _____
- ❑ CVA _____
- ❑ Diabetes _____
- ❑ Glaucoma _____
- ❑ Heart Disease _____
- ❑ Hypertension _____
- ❑ Macular Degeneration _____
- ❑ Retinal Detachment _____

Other: _____

_____

_____

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**_____

_____

Physician Signature_____ **Date**_____

Updated with patient Yes ❑ **No** ❑ **Date**_____