

# PATIENT HISTORY RECORD

\_\_\_\_\_  
Patient Name Date

**Please answer the following questions about your medical status and history.**

1. Do you smoke?      Yes \_\_\_      No \_\_\_      If yes, how much \_\_\_\_\_
2. Do you drink alcohol?      Yes \_\_\_      No \_\_\_      If yes, how much \_\_\_\_\_
3. Do you have any drug or food allergies?      Yes \_\_\_      No \_\_\_  
If Yes, please list \_\_\_\_\_
4. Do any medical or eye diseases run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?  
Yes \_\_\_      No \_\_\_      If Yes, please list \_\_\_\_\_
5. Have you ever been treated for any medical conditions (diabetes, high blood pressure, arthritis, etc.)?      Yes \_\_\_      No \_\_\_  
If Yes, please explain \_\_\_\_\_
6. Have you ever had an eye disease (glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?      Yes \_\_\_      No \_\_\_  
If Yes, please explain \_\_\_\_\_
7. Have you ever had any surgery?      Yes \_\_\_      No \_\_\_  
If Yes, please list \_\_\_\_\_
8. Have you ever been hospitalized?      Yes \_\_\_      No \_\_\_  
If Yes, please list \_\_\_\_\_
9. Are you currently pregnant?      Yes \_\_\_      No \_\_\_
10. Do you take any medications?      Yes \_\_\_      No \_\_\_  
If Yes, please list \_\_\_\_\_

<b>Review of Systems</b>	<b>Yes</b>	<b>No</b>	<b>If YES, please explain:</b>
Do you currently have any of the following problems:			
Chronic fever, unexpected weight loss/gain, fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (hearing loss, sinus problems, sore throat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (shortness of breath, wheezing, coughing).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (heartburn, stomach pain, diarrhea, vomiting).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (pain or discomfort, blood in urine).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (rashes, excessive dryness).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscular-skeletal problems (muscle aches, joint pain, swollen joints).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological problems (numbness, weakness, headaches, paralysis).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (depression, anxiety).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Comments \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE DATE