Patient History Record

Today's Date: Referred by: Date of Birth:

Patient Name: Sex: Age: Home phone#: ( )

Street Address: City: State: Zip:

Employer: Occupation: Work/Cell phone#: ( )

Social Security Number: Primary Care Physician:

Please answer the following questions about your medical history:

1) Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, ect.)?
   Yes ☐ No ☐ If **yes**, please explain: _____
2) Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   Yes ☐ No ☐ If **yes**, please explain: _____
3) Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration) Yes ☐ No ☐ If **yes**, please list: _____
4) Have you ever had any surgery? Yes ☐ No ☐ If **yes**, please explain: _____
5) Have you ever been hospitalized? Yes ☐ No ☐ If **yes**, please explain: _____
6) Do you take any medications? Yes ☐ No ☐ If **yes**, please explain: _____
   _____
7) Do you have any drug or food allergies? Yes ☐ No ☐ If **yes**, please explain: _____
8) Do you have a **LATEX** allergy? Yes ☐ No ☐ If **yes**, please explain: _____
9) Do you smoke? Yes ☐ No ☐ If **yes**, how much per week: _____
10) Do you drink alcohol? Yes ☐ No ☐ If **yes**, how much per week: _____

Do you have any of the following problems?	**YES**	**NO**	**If yes, please explain:**
Chronic Fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/Nose/Throat problems (e.g. hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	
Urinary problems (e.g. pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g. rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	☐	☐	
Neurological problems (e.g. numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g. depression, anxiety)	☐	☐	

Doctor Signature _____ Date_____

Doctor reviewed history _____ Date_____