Patient History Form – First Visit

M/R#_____

Patient:_____

Please answer the following questions about your health:

Have you ever been treated for any medical conditions?
Diabetes: ___NO __ YES
High blood pressure ___ NO __ YES
Heart Disease: ___ NO __ YES
Others (please explain):_____

Have you ever had any eye diseases?
Glaucoma ___ NO ___ YES
Cataracts ___ NO ___ YES
Macular Degeneration ___ NO ___ YES
Diabetic eye disease ___ NO ___ YES
Others: _____
_____

Have you had eye surgery (including laser surgery)? ___ NO ___ YES

Type of Surgery	Date	Eye
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had surgery or been hospitalized? ___ NO ___ YES
Please describe:_____
_____

Do you take any medications (including eye drops) ? ___ NO ___ YES
Please list: _____
_____
_____

Do you have any drug or food allergies? ___ NO ___ YES
Please list:_____

Do any medical or ocular diseases run in your family?
Eye: _____
Others:_____

Do you currently have any of the following problems?

Chronic fever, unexplained weight loss, fatigue? __ NO __ YES _____
Ear/Nose/Throat problems (sinusitis, etc.) __ NO __ YES_____
Respiratory problems (shortness of breath, coughing, etc.) __ NO __ YES_____
Heart problems (chest pain, palpitations, etc.) __ NO __ YES _____
Gastrointestinal problems (Diarrhea, nausea, abdominal pain) __ NO __ YES _____
Urinary problems (pain or blood in urine, etc.) __ NO __ YES_____
Skin problems (Rashes, etc.) __ NO __ YES _____
Musculoskeletal problems (Joint pain, swelling) __ NO __ YES_____
Neurologic problems (Weakness, numbness, headache, etc.) __ NO __ YES_____
Psychiatric problems (Depression, insomnia, etc.) __ NO __ YES_____
Allergy Symptoms

Asthma	__ NO	__ YES
Congestion	__ NO	__ YES
Runny nose	__ NO	__ YES
Dark circles under eye	__ NO	__ YES
Itchy/flaky skin	__ NO	__ YES

Eyes:

Blurred Vision	__ NO	__ YES _____
Double Vision	__ NO	__ YES _____
Floaters	__ NO	__ YES_____
Dry, sandy, gritty	__ NO	__ YES_____
Itchy	__ NO	__ YES
Red	__ NO	__ YES
Watery	__ NO	__ YES
Swollen	__ NO	__ YES
Foreign Body Sensation	__ NO	__ YES

Other:_____
_____
_____

Do you smoke? __ NO __ YES How much? _____
Drink alcohol? __ NO __ YES How much? _____