

PATIENT'S PERSONAL HISTORY - PLEASE COMPLETE ALL INFORMATION

Please Print

(THANK YOU!)

Last Name _____ First Name _____ Middle Initial _____ Title _____ Date _____

What are your visual problems & symptoms? _____ How long? _____

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

1. Do you have any drug or food allergies? What are you allergic to? _____

Yes No If yes, list symptoms: _____

2. Are you allergic to latex? Yes No If yes, list symptoms: _____

3. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, heart disease, stroke, asthma, cholesterol, thyroid problems, cancer or been hospitalized)?

Yes No If yes, please explain: _____

4. Have you ever had asthma, emphysema, or been treated for any breathing difficulties? Yes No

5. Have you ever been treated for any eye disease or had any eye surgery or eye injury?

Yes No If yes, please provide date and details: _____

6. Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cataract, glaucoma, macular degeneration)?

Yes No If yes, please specify family members with these conditions: _____

Family and Social History

Do you:	Yes	No	Do you:	Yes	No
Wear glasses*			Use eye drops (prescription & over the counter?) List:		
Wear contacts* <input type="checkbox"/> Soft <input type="checkbox"/> Hard					
Do you smoke? If yes, how much? ____ (packs) How Long? ____ (years)			Do you work? If yes, how many hours per week? What kind of work do you do? List:		
Do you drink alcohol? If yes, how much? ____					
How much do you weigh?					
Do you have Difficulty:			Do you have Difficulty:		
Driving? <input type="checkbox"/> With Glasses <input type="checkbox"/> Without Glasses			Seeing at night?		
With headlights? <input type="checkbox"/> With Glasses <input type="checkbox"/> Without Glasses			In bright light?		
Seeing road signs? <input type="checkbox"/> With Glasses <input type="checkbox"/> Without Glasses			Crossing the street?		
Reading? <input type="checkbox"/> With Glasses <input type="checkbox"/> Without Glasses			Recognizing the faces of people across the street?		

* Who wrote your prescription for the glasses/contacts you are wearing? _____

* When was your last visit to the optometrist? _____

PLEASE TURN PAGE OVER TO CONTINUE 

REVIEW OF SYSTEMS

Do you currently have any of the following problems:

Yes No If Yes, please explain

- | | | | |
|--|--------------------------|--------------------------|-------|
| Chronic fever, fatigue, unexpected weight gain/loss | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ear/nose/throat problems (e.g. hearing loss, sinus infection, sore throat) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart problems (e.g. chest pain, irregular heart beat, high blood pressure) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Respiratory problems (e.g. shortness of breath, wheezing, coughing, asthma) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Urinary problems (e.g. pain or discomfort, blood in urine), difficulty voiding | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Skin problems (e.g. rashes, excessive dryness) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Neurological problems (e.g. numbness, weakness, headache) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Psychiatric problems (e.g. depression, anxiety) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Endocrine problems (e.g. diabetes, thyroid disease) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Blood problems (e.g. anemia, bleeding tendency) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever been exposed to Hepatitis B? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever been exposed to Hepatitis C? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Have you ever tested positive for the HIV Virus? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Do you drive? Yes No

Please list your prescription and over-the-counter medication, including vitamins and daily aspirin _____

- THANK YOU -

Please use space below if needed for further explanations.
