

Patient Health History

Patient Name		Date of Birth	
Primary Care Physician		Approximately when was your Last Visit at PCP Office	Reason for Last Visit at PCP Office
Last Eye Doctor		Approximately when was your last eye exam	
If Female: Are you pregnant? Yes No Are you nursing? Yes No			

Review Of Systems	
Please list any current illnesses, symptoms or problems	
Do you have any of the following:	Fever Fatigue Sudden Weight Loss Sudden Weight Gain
Cardiovascular	
Ears, Nose, Mouth, Throat	
Respiratory / Lungs	
Stomach / Intestines	
Urinary / Reproductive	
Bones / Joints / Muscles	
Skin / Hair / Nails	
Neurological	
Psychiatric	
Endocrine / Hormonal	
Blood / Circulation	
Allergic / Immunologic	
Other	

Diabetic Information							
Type of Test	SMBS: Self Monitoring Blood Sugar test HgbA1c: Hemoglobin A1c test						
	<table border="1"> <tr> <td>Date of Last Recorded Test</td> <td></td> </tr> <tr> <td>Value</td> <td></td> </tr> <tr> <td>Location / Timing</td> <td></td> </tr> </table>	Date of Last Recorded Test		Value		Location / Timing	
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Eye Surgery Information				
Date	Eye	Procedure	Surgeon	Complications

Past / Present Ocular History		
Please list any past or present ocular illnesses, symptoms or problems		Date Diagnosed
Glaucoma		
Cataracts		
Age-Related Macular Degeneration		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Strabismus		
Amblyopia		
Diabetic Retinopathy		
Dry Eye		
Refractive Problems		

Do you work on a computer?		Hours per day	
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Social History	
Do you use recreational drugs? If so, what type?	
Do you drink alcohol? If so, what type do you drink, how much and how often?	
Are you a smoker, former smoker or never smoked? If you are a smoker, do you smoke everyday or some days?	
Do you use tobacco? If so, what type, how much, how often and for how long?	
Occupation	
Hobbies	

Family History		
Please list any family members with these conditions		
MGM (maternal grandmother) MGF (maternal grandfather)	PGM (paternal grandmother) PGF (paternal grandfather)	MGP (maternal grandparents) PGP (paternal grandparents)
Glaucoma		
Cataracts		
Age-Related Macular Degeneration		

Family History

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MGM (maternal grandmother)
MGF (maternal grandfather)

PGM (paternal grandmother)
PGF (paternal grandfather)

MGP (maternal grandparents)
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Eye Injury	
Retinal Disease	
Other Disease	
Blindness	
Strabismus	
Amblyopia	
Diabetes	
Cancer	
Hypertension	
Heart Disease	
High Cholesterol	
Kidney Disease	

Medication Allergies

Allergy	Onset Date	Reaction	Severity

Medications

Please list all prescriptions, over the counter and herbal medications

Date	Name	Strength	Directions

Contact Lens History

Type of contact lenses you currently use (gas permeable, soft)		How often do you replace your contacts? (daily, 2 weeks, monthly)	
Average number of hours that you wear your contacts each day	Number of hours worn today	Do you sleep in your contacts?	