PATIENT HISTORY FORM

Chief Complaint/Reason for my visit:	
Location	Which Eye?
Quality	What are you experiencing?
Severity	How bad is it?
Duration	When did the problem start?
Timing	How long does it usually last?
Context	In what setting does it occur?
Modifying Factor	What makes it better or worse?
Associated Symptoms	Other symptoms that occur?
Treatments	How have you treated the problem?

Referring Optometrist_____ Primary Care Doctor_____

Do you Have any allergies?

❑ No ❑ Yes, Please list_____

Do you use tobacco, alcohol or recreational drugs?

❑ No ❑ Yes, please comment_____

Family Medical History - Does anyone in your family have the following?

❑ Glaucoma ❑ Diabetes ❑ Crossed Eyes ❑ None

❑ Blindness ❑ Cancer ❑ Heart Disease

❑ Other_____

Please list names and doses of all medications you take:

Medication	Dosage	Medication	Dosage

List all previous operations / treatments / injuries / illnesses

Date	Description

Additional Comments:

NAME:_____ DOB _____ DATE_____

REVIEW OF SYSTEMS

Please check those things which apply to you.

Eyes

- ❑ Glasses
- ❑ Contacts
- ❑ Pain
- ❑ Redness
- ❑ Discharge
- ❑ Tearing
- ❑ Itching
- ❑ Swelling
- ❑ Light Sensitivity
- ❑ Floaters
- ❑ Double Vision
- ❑ Distortion
- ❑ Loss of Color
- ❑ NONE

Cardiovascular

- ❑ Chest Pain / Angina
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ Irregular heartbeat
- ❑ Heart murmur
- ❑ NONE

Respiratory

- ❑ Asthma
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Productive cough
- ❑ Turberculosis
- ❑ NONE

Musculoskeletal

- ❑ Muscle Cramps / Spasm
- ❑ Weakness
- ❑ Arthritis
- ❑ Aching Joints
- ❑ Swelling Joints
- ❑ NONE

Gastrointestinal

- ❑ Special diet
- ❑ Abdominal pain
- ❑ Indigestion
- ❑ Nausea / Vomiting
- ❑ Liver disease
- ❑ Diarrhea / Constipation
- ❑ Passing blood
- ❑ Change in stool color
- ❑ NONE

Genitourinary

- ❑ Kidney stones
- ❑ Bladder stones
- ❑ Infections
- ❑ Burning urine
- ❑ Genital discharge
- ❑ Dialysis
- ❑ NONE

Endocrine

- ❑ Excessive sweating
- ❑ Heat / cold intolerance
- ❑ Severe thirst
- ❑ Altered Menstrual cycle
- ❑ Infertility
- ❑ NONE

Constitutional Problems

- ❑ Fatigue
- ❑ Fever
- ❑ Weight loss
- ❑ Loss of appetite
- ❑ NONE

Skin and / or Breast

- ❑ Rashes
- ❑ Change of skin color
- ❑ Loss of hair
- ❑ Breast lumps / surgery
- ❑ NONE

Diabetes controlled by

- ❑ Diet
- ❑ Insulin
- ❑ Oral medication
- ❑ NONE

Ear/Nose/Mouth/Throat

- ❑ Ringing ears
- ❑ Difficulty hearing
- ❑ Difficulty chewing
- ❑ Difficulty swallowing
- ❑ Difficulty speaking
- ❑ NONE

Psychiatric

- ❑ Memory loss
- ❑ Poor concentration
- ❑ Sleeplessness
- ❑ Early waking
- ❑ Depression
- ❑ Anxiety attacks
- ❑ NONE

Neurological

- ❑ Stroke
- ❑ Epilepsy
- ❑ Headaches / Migraines
- ❑ Loss of Balance
- ❑ Numbness / Tingling
- ❑ Tremors
- ❑ NONE

NAME_____DOB_____DATE_____