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Patient History Record

Name:_____ **Age:**_____ **Today's Date:**_____

Reason for today's visit:_____

1. Please circle: Do you wear glasses? (Yes or No), Do you wear contact lenses? (Yes or No)

2. Are you currently experiencing any of the following eye symptoms? Please circle all that apply.

Eye Pain **Blurred Vision** **Eyelid Crusting** **Flashes of Light** **Halos**

Discharge **Light Sensitivity** **Double Vision** **Decreased Vision** **Floaters**

Problems reading

3. Have you ever had eye surgery or an eye injury? If so, please indicate which eye and what injury occurred or what type of surgery was performed. Please give approximate dates as well.

_____

_____

4. Have you ever had any surgery (other than eye surgery)? If so, please list:_____

_____

_____

Do you have or do you have a family history of: If yes, please circle self or family. If not, leave blank.

Blindness	Self	or	Family	**Macular degeneration**	Self	or	Family
Glaucoma	Self	or	Family	**Retinal Detachment**	Self	or	Family
Vision Loss	Self	or	Family	**Amblyopia (lazy eye)**	Self	or	Family
Cataracts	Self	or	Family	**Inflammation of eyes**	Self	or	Family

Please explain:_____

_____

5. Please list your hobbies or interests:_____

6. If retired, please list your previous occupation: _____

7. Have you ever smoked? Yes_____ No_____ When did you quit? _____

8. Do you drink alcohol? Yes_____ No_____ If yes, how much in a typical day? _____

9. Do you use illegal drugs? Yes _____ No _____

10. Health status of parents, siblings and/or children or cause of death? _____

_____

11. Are you current with your immunizations? Yes _____ No_____ Date of last tetanus _____

12. Are you allergic to any medications? If so, please list:_____

_____

13. Please list ALL eye medications you are currently using: _____

_____

(Turn Over and Complete Back Side)