Patient Health Record

Personal Eye History:

Date of Last Exam: _____ HOW old are your glasses? _____ DO you wear contact lenses? ☐ Yes ☐ No

Do you work on a computer? ☐ Yes ☐ No Approximately how many hours per day? _____

Previous Eye Injuries..... ☐ Yes ☐ NO _____ Cataracts. ..... ☐ Yes ☐ No _____

Previous EYE SURGERY..... ☐ Yes ☐ No _____ Macular Degeneration.... ☐ Yes ☐ No _____

Glaucoma..... ☐ Yes ☐ No _____ Retinal Detachment..... ☐ Yes ☐ No _____

Dry Eyes..... ☐ Yes ☐ No _____ Floaters……..... ☐ Yes ☐ No _____

Family Eye/Medical History:

Glaucoma..... ☐ Yes ☐ No Family Member: _____

Cataracts..... ☐ Yes ☐ No Family Member: _____

Retinal Detachment..... ☐ Yes ☐ No Family Member: _____

Eye Muscle Imbalance..... ☐ Yes ☐ No Family Member: _____

Diabetes ..... ☐ Yes ☐ No Family Member: _____

Other..... ☐ Yes ☐ No Family Member: _____

Many diseases of the body have serious eye health consequences. For example, diabetes is one of the leading causes of blindness. Therefore, it IS IMPORTANT that we acquire an in-depth medical history. Please answer the following questions. while they may seem unrelated to an eye problem, it is crucial to your care that we ask them. this information is also critical in the event we need to prescribe certain medications.

Personal Medical History:

Are you presently under the care of a physician? ☐ Yes ☐ No

If yes, for what reason? _____

Are you taking any medications now? ☐ Yes ☐ No

If yes, please list all medications: _____

Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you taking any medications that don't need a prescription? ☐ Yes ☐ No

If yes, please list: _____

Are you allergic to: ☐ Antibiotics ☐ Local Anesthetics ☐ Sulfa drugs ☐ Penicillin

Are you allergic to any other medications? _____

Do you smoke cigarettes? ☐ Yes ☐ No How many per day? _____

Do you consume alcohol on a daily basis? ☐ Yes ☐ No

Is your blood pressure ☐ high ☐ low ☐ normal

Women: Are you pregnant? ☐ Yes ☐ No How long? _____

Do you have, or have you ever been informed that you had, any of the following:

Chest Pains..... ☐ Yes ☐ No

Heart Disease..... ☐ Yes ☐ No

Headaches..... ☐ Yes ☐ No

Lung Problems..... ☐ Yes ☐ No

Hypertension..... ☐ Yes ☐ No

Stroke..... ☐ Yes ☐ No

Allergies or Hives..... ☐ Yes ☐ No

HIV Disease..... ☐ Yes ☐ No

Thyroid Problems..... ☐ Yes ☐ No

Hormonal Problems..... ☐ Yes ☐ No

Tuberculosis..... ☐ Yes ☐ No

Diabetes..... . ☐ Yes ☐ No

Epilepsy or Seizures..... ☐ Yes ☐ No

High Cholesterol..... ☐ Yes ☐ No

Persistent Cough..... ☐ Yes ☐ No

Skin Disease..... ☐ Yes ☐ No

Migraines..... ☐ Yes ☐ No

Cancer or Leukemia..... ☐ Yes ☐ No

Sickle Cell Disease..... .☐ Yes ☐ No

Sarcoidosis..... ☐ Yes ☐ No

Lupus..... ☐ Yes ☐ No

Lyme DISEASE..... ☐ Yes ☐ No

Asthma or Hay Fever..... ☐ Yes ☐ No

Sinus Trouble..... ☐ Yes ☐ No

Arthritis..... ☐ Yes ☐ No

AIDS..... ☐ Yes ☐ No

Enlarged Lymph Nodes..... ☐ Yes ☐ No

Excessive Urination and/or Thirst..... ☐ Yes ☐ No

Multiple Sclerosis..... ☐ Yes ☐ No

Sexually Transmitted Diseases..... ☐ Yes ☐ No
(Gonorrhea, Syphilis, Genital Herpes)

Repeated Cold Sores or Canker Sores.... ☐ Yes ☐ No

Do you suffer from any disease not listed above? ☐ Yes ☐ NO. IF yes, please list: _____