PATIENT HISTORY FORM –Adapted from the American Academy of Ophthalmology

Name ______________________________________ M☐ F☐ Birth Date ______________ Today's Date ______________

Primary Care Physician _________________________________ Referring Physician/Person ______________________________

Pharmacy ____ Phone Number ____

REVIEW OF SYMPTOMS
What is your primary concern about your eyes/vision **TODAY**?____

Do you presently have any problems in the following areas? If "YES", give an explanation

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision	☐	☐	
Loss of side vision, double vision	☐	☐	
Itching, burning, or discharge	☐	☐	
Redness	☐	☐	
Gritty feeling, dryness or tearing	☐	☐	
Glare/light sensitivity, or halos	☐	☐	
Eye pain or soreness	☐	☐	
Infection of eyelashes or lid, stye(s)	☐	☐	
Ears, nose, mouth, throat	☐	☐	
Cardiovascular, (heart, blood vessels)	☐	☐	
Respiratory (lungs/breathing)	☐	☐	
Gastrointestinal (stomach/intestines)	☐	☐	
Genitourinary (genitals/kidney/bladder)	☐	☐	
Musculoskeletal (muscles/joints)	☐	☐	
Integument (skin/breast)	☐	☐	
Neurological	☐	☐	
Psychiatric	☐	☐	
Endocrine (hormones, glands	☐	☐	
Hematologic/Immunologic (blood)	☐	☐	
Seasonal allergies (hay fever, etc.)	☐	☐	

PAST HISTORY (EYE)

	YES	NO	
Eye drops currently in use:	☐	☐	List name of medication, dosage and frequency:
Allergies to eye drops	☐	☐	List drops you are allergic to
History of cataract, glaucoma	☐	☐	
History of cross/lazy eye	☐	☐	
Eye injury or other disease	☐	☐	List Eye Surgery information:
Eye surgery	☐	☐	

PAST HISTORY (MEDICAL)

List any medications (other than eye drops) that you are currently using:

Medication	**Dosage**	**Frequency**

List all major illnesses: Diabetes ______________ Hypertension _______________

Other:

List any major surgical procedures:

Do you have any medication allergies? ☐NO ☐ YES Penicillin Sulfa

List any other medication allergies:

FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP
OCULAR	☐	☐	______
Blindness	☐	☐	______
Cataract	☐	☐	______
Glaucoma	☐	☐	______
Macular degeneration	☐	☐	______
Retinal detachment	☐	☐	______
Diabetic Eye Disease	☐	☐	______
MEDICAL			
Diabetes	☐	☐	______
Arthritis, lupus, etc.	☐	☐	______
Other (list)	☐	☐	______

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCULAR			
Have you ever tried to wear contacts?	☐	☐	______
Did you have problems with contacts?	☐	☐	______

Vision causes problems with:

☐ Driving ☐ Night vision ☐ Reading ☐ Sports/Outdoor activities

General

	YES	NO	EXPLANATION
Do you drink alcohol?	☐	☐	How much per day?______
Do you use tobacco products	☐	☐	Type/How much per day?______
Have you ever had a blood transfusion?	☐	☐	
Have you ever had contact with a person who had a sexually transmitted disease?	☐	☐	

Patient's signature:____ Date: ___________________

History reviewed ☐ No changes ☐ Additions as noted

Physician's signature: ____ Date: ____________________