Pharmacy Name:_____
Address:_____
City:_____State:_____Zip:_____
Phone Number:_____

PATIENT HISTORY FORM

Thank you for choosing our practice. Date_____

Last name_____ First_____ M.I.__ E-Mail_____

Date of Birth_____ Sex_____ How did you hear about us?_____

Address_____ City_____ State_____ ZIP_____

Phone: Home_____ Work_____ Cell_____

Last 4 of SS #_____ Occupation_____ Insurance ID # _____

Were you referred here by another Doctor? ☐ Yes ☐ No If yes which Dr.?_____

EYE HISTORY

Do you currently wear ☐ Glasses ☐ Contact lenses ☐ Neither

Do you have visual difficulty when reading? ☐ Yes ☐ No

Do you have visual difficulty when driving or seeing far away ☐ Yes ☐ No

Are you currently using any prescription or over the counter medications or drops for your eyes? ☐ Yes ☐ No If yes, please list:_____

Have you ever had eye surgery? ☐ Yes ☐ No If yes, please describe:

☐ Right Eye – Type of surgery:_____ Date_____

☐ Left Eye – Type of surgery:_____ Date_____

Have you ever injured your eyes? ☐ Yes ☐ No If yes, please describe _____

_____

Have you ever had or do you have any of the following eye conditions? If YES for how long? _____

	Currently	Past	Never		Currently	Past	Never
Glaucoma	☐	☐	☐	Halos	☐	☐	☐
Macular Degeneration	☐	☐	☐	Light sensitivity	☐	☐	☐
Cataracts	☐	☐	☐	Redness	☐	☐	☐
Retinal tear or detachment	☐	☐	☐	Itching	☐	☐	☐
Lazy eye/eye patching	☐	☐	☐	Burning	☐	☐	☐
Eye pain	☐	☐	☐	Dryness	☐	☐	☐
Blurred, decreased vision	☐	☐	☐	Sandy/gritty eye(s)	☐	☐	☐
Plaquenil Use	☐	☐	☐	Foreign body sensation	☐	☐	☐
Flashes of light in eye(s)	☐	☐	☐	Discharge	☐	☐	☐
Floating dark spots in eye(s)	☐	☐	☐	Crusting on eyelid	☐	☐	☐
Double Vision	☐	☐	☐	Drooping eyelid	☐	☐	☐

Other_____

MEDICAL HISTORY

Are you currently being treated for any of the following? ☐ **High Blood Pressure** ☐ **Diabetes**

☐ Heart Disease ☐ Stroke ☐ Arthritis ☐ Other_____

Have you ever been treated for any other serious illness or medical conditions or have had any hospitalizations or surgery? If Yes, please explain_____

_____

_____

_____

Please list any medications that you take, prescription or over the counter or herbal remedies

_____

_____

_____

Do you have any: ☐ **Drug Allergies?** If yes, please list and explain reaction(s): _____

_____

☐ **Seasonal Allergies?** If yes, please list and explain reaction(s) and if you take anything for them._____

_____

Review of Systems: Are you currently experiencing problems with any of the following?

			If yes, please explain
Chronic Fever, sudden weight loss/gain, fatigue	☐ Yes	☐ No	_____
Heart (e.g. chest pain, irregular heartbeat, hypertension)	☐ Yes	☐ No	_____
Respiratory (e.g. cough, wheezing, shortness of breath)	☐ Yes	☐ No	_____
Ear/nose/throat (e.g. hearing loss, sinus, sore throat)	☐ Yes	☐ No	_____
Gastrointestinal (e.g. heartburn, belly pain, diarrhea)	☐ Yes	☐ No	_____
Urinary (e.g. pain, frequent urination, blood in urine)	☐ Yes	☐ No	_____
Skin problems (e.g. dry skin, rashes, dermatitis, itching)	☐ Yes	☐ No	_____
Musculoskeletal (e.g. muscle aches, joint pain or swelling)	☐ Yes	☐ No	_____
Endocrine (e.g. diabetes, thyroid)	☐ Yes	☐ No	_____
Hematologic/lymphatic (e.g. leukemia, enlarged glands)	☐ Yes	☐ No	_____
Psychiatric (e.g. depression, anxiety, confusion)	☐ Yes	☐ No	_____
Neurological (e.g. numbness, weakness, headaches)	☐ Yes	☐ No	_____

Social History

Martial Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of Alcohol: ☐ Never ☐ Rarely ☐ Socially/moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Former use ☐ Current, how much?_____

Use of recreational drugs: ☐ Never ☐ Former use ☐ Current, what and how much?_____

_____

Family Medical/Eye History(e.g. diabetes, glaucoma, retinal tears/detachment, macular degen)

	Approx. Age at diagnosis	Medical/Eye Disease
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
	_____	_____
Children	_____	_____
	_____	_____

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____ _____

Signature of patient (or guardian, if minor) Date