

FOR OFFICE USE ONLY

CHART#: \_\_\_\_\_  
 EXAM DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## PATIENT HISTORY

PATIENT: \_\_\_\_\_ D/O/B: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

PRIMARY CARE DR: \_\_\_\_\_ REFERRING DR: \_\_\_\_\_

PRIMARY CARE DR. ADDRESS: \_\_\_\_\_ REFERRING DR. ADDRESS: \_\_\_\_\_

PRIMARY CARE DR. PHONE: \_\_\_\_\_ REFERRING DR. PHONE: \_\_\_\_\_

ALLERGIES \_\_\_\_\_

EYE MEDICATIONS			OTHER MEDICATIONS		
NAME	STRENGTH	FREQUENCY	NAME	STRENGTH	FREQUENCY

### PAST EYE HISTORY

(Please Check)

DO YOU HAVE	NO	YES RIGHT EYE	YES LEFT EYE	COMMENTS
Distance Glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading Glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurry Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes of Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>HAVE YOU HAD</b>				
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

### SOCIAL HISTORY

Marital Status (*circle one*)      **S**ingle      **M**arried      **D**ivorced      **W**idowed  
 Live Alone      **Yes**       **No**       Assisted Living Facility   
 Tobacco Use      **Yes**       **No**       Pack / Years \_\_\_\_\_  
 Alcohol Use      **Yes**       **No**       Drink / Week \_\_\_\_\_  
 Occupation \_\_\_\_\_ Retired   
 Hobbies \_\_\_\_\_  
 Do You Have Advanced Directives (Living Will)?      YES       NO

### PAST MEDICAL HISTORY

SYSTEM	NO	YES	COMMENTS
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Trauma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, Nose, Throat Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breathing Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Digestive Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary Tract Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine Diseases (ie, THYROID)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal Changes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wear Hearing Aids?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
What Was The Date Of Your Last Tetanus Shot?	_____		

**PAST MEDICAL HISTORY**

---

---

---

**PAST SURGICAL HISTORY**

---

---

---

**FAMILY HISTORY**

	FATHER	MOTHER	SIBLING	COMMENTS
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

DATE: \_\_\_\_\_ TECH: \_\_\_\_\_ DR: \_\_\_\_\_

