# PATIENT HISTORY FORM

**Date: _____/_____/_____**

**Name:_____ Sex:_____**

**DOB:_____/_____/_____ Address:_____**

**City:_____ State:_____ Zip:_____**

**Home Phone:_____ Cell Phone:_____**

**SSN:_____ Email:_____**

**Occupation:_____ Employer:_____**

**Primary Care Physician:_____**

**Primary Care Physician Phone:_____**

**Preferred Pharmacy:_____**

**Emergency Contact: _____ Relation:_____**

**Emergency Contact Phone:_____**

**Are you interested in any of the following:**

- ( ) New Spectacles
- ( ) Contacts
- ( ) Sunglasses
- ( ) Dry eye therapy
- ( ) Safety Glasses
- ( ) LASIK

**Social History:**

- ( ) Alcohol Abuse
- ( ) Drug Use: _____
- ( ) Tobacco Use
- ( ) Marijuana Use
- ( ) Other:_____

**MEDICATION ALLERGIES & CURRENT MEDICATIONS**

Medication allergies: ( ) No ( ) Yes (List below)

Please list the allergy and reaction to the medication

1. _____Reaction:_____

2. _____Reaction:_____

3. _____Reaction:_____

4. _____Reaction:_____

5. _____Reaction:_____

Please list any medications that you are taking. Include non-prescription medications & vitamins or supplements:

| **Name of Medication (include dosage)** |
|---|
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| 7. |
| 8. |
| 9. |
| 10. |

## PAST MEDICAL HISTORY

Check all that apply:

- ( ) Diabetes
- ( ) Heart murmur
- ( ) Heart problems
- ( ) High blood pressure
- ( ) High cholesterol
- ( ) Pulmonary embolism
- ( ) Thyroid Dysfunction
- ( ) Macular Degeneration
- ( ) Cataracts
- ( ) Glaucoma
- ( ) Asthma
- ( ) Emphysema
- ( ) COPD
- ( ) Stroke
- ( ) Seizures
- ( ) Epilepsy
- ( ) Migraines
- ( ) Cancer (type) _____
- ( ) Kidney disease
- ( ) Seasonal Allergies
- ( ) Psoriasis
- ( ) Arthritis
- ( ) Rheumatoid Arthritis

Other medical conditions (please list):

## DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

Check all that apply:

- ( ) Blurry Distance Vision
- ( ) Blurry Near Vision
- ( ) Poor Night Vision
- ( ) Red Eyes
- ( ) Sandy/Dry eyes
- ( ) Discomfort in Sunlight
- ( ) Glare/Reflections
- ( ) Double Vision
- ( ) Black Spots/Floaters
- ( ) Crossed eyes
- ( ) Lazy eye
- ( ) Watering Eyes
- ( ) Ocular Allergies
- ( ) Itchy Eyes
- ( ) Pain in eye
- ( ) Burning
- ( ) Flashes of Light
- ( ) History of Ocular Surgery:_____
- ( ) Discharge
- ( ) Headaches
- ( ) Eye Injury:_____

Other ocular issues to speak about:

## FAMILY OCULAR CONDITIONS

Check all that apply and list who:

- ( ) Glaucoma: _____
- ( ) Keratoconus:_____
- ( ) Macular Degeneration:_____
- ( ) Retinal Detachments:_____
- ( ) Cataracts:_____
- ( ) Diabetic retinopathy:_____