

PATIENT HISTORY RECORD

Form with fields: DATE (MM/DD/YY), REFERRED BY, BIRTH DATE, PATIENT'S NAME, SEX, AGE, ADDRESS, CITY, ST., ZIP, PHONE (H), EMPLOYER, OCCUPATION, PHONE (W), SOC. SEC. NO., PRIMARY CARE PHYSICIAN

Please answer the following questions about your medical status and history:

- 1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
3. Have you ever had any surgery?
4. Have you ever been hospitalized
5. Do you take any medications?
6. Do you have any drug or food allergies?

Review of Systems

Review of Systems table with columns: Yes, No, If YES, please explain:
Do you currently have any of the follow problems:
Chronic fever, unexpected weight loss/gain, fatigue
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)
Heart problems (e.g. chest pain, irregular heart beat)
Respiratory problems (e.g., shortness of breath, wheezing, coughing)
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)
Urinary problems (e.g. pain or discomfort, blood in urine)
Skin problems (e.g. rashes, excessive dryness)
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)
Psychiatric problems (e.g., depression, anxiety)
7. Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

8. Do you smoke? Yes No how much? [] drink alcohol? Yes No how much? []
If employed, how many hours per week do you work? []

Comments

Patient's Signature

Date