Patient Medical History

Name: ______________________ Date: ____________

Chief Complaint

Why would you like to see the doctor?

____

____

____

Review of Systems

Please indicate and explain, if you have or have ever had a problem in any of the following areas:

	YES	NO	EXPLAIN
Eyes			
Ears, Nose & Throat			
Cardiovascular (high b.p., stroke)			
Respiratory (asthma,etc.)			
GI (stomach, bowels)			
GU (bladder, prostate)			
Skin			
Musculoskeletal (arthritis)			
Neurological			
Blood/Lymph			
Allergy/Immune			
Endocrine (thyroid, diabetes)			
Other (please specify)			

Social History

Do you use any of the following? If so indicate amount and frequency.

	YES	NO	EXPLAIN
Drugs Alcohol			
Tobacco			
Occupational Exposure			
Other (please specify)			

(continued on other side)

Patient Medical History (continued)

Do you or anyone in your family have any of the following illnesses?
Please specify which relative. (e.g. self, mother, brother, etc.)

	YES	NO	RELATIVE
Glaucoma	______	______	______
Cataracts	______	______	______
Nearsighted	______	______	______
Macular Degeneration	______	______	______
Keratoconus	______	______	______
Retinal Detachment	______	______	______
Blindness	______	______	______
Other (please specify)	______		

Do your wear the following? Please circle all that apply.

Glasses: Distance Reading Bifocal Trifocal

Contact Lenses: Hard Gas Permeable Soft-Daily Soft-Extended

How old are the glasses or contacts? ______

Optician who made the glasses or contacts? ______

Medications

NAME	DOSAGE	FREQUENCY
______	______	______
______	______	______
______	______	______

Ocular Medications

NAME	DOSAGE	FREQUENCY
______	______	______
______	______	______
______	______	______

Allergies

______

______

______ Technician Signature ______ Date Reviewed

______ Doctor Signature ______ Date Reviewed