Patient History and Information

Primary Care Physician

Primary Care Physician Name _____ Clinic Name _____

Primary Care Physician Address _____ City _____ State _____ ZIP _____

Referring Physician

Referring Physician Name _____ Clinic Name _____

Referring Physician Address _____ City _____ State _____ ZIP _____

Health History

What is the main reason for today's exam? _____

Date of last exam _____ Date of last health exam _____

Past Illnesses or Injuries: _____

_____

Past Surgeries: _____

_____

Current Medications: _____

_____

Current Eyedrops: _____

Specific Allergies: _____

Medicines that cause reactions or sensitivities: _____

Eye History

- ☐ Glaucoma
- ☐ Cateract
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Color Blindness
- ☐ Headaches
- ☐ Glare/Light Sensitivity
- ☐ Tired Eyes
- ☐ Amblyopia (Lazy Eye)
- ☐ Burning
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Pain or Soreness
- ☐ Foreign Body Sensation
- ☐ Infection of Eye or Lid
- ☐ Itching
- ☐ Mucous Discharge
- ☐ Drooping Eyelid
- ☐ Redness
- ☐ Sandy/Gritty Feeling
- ☐ Strabismus (Crossed Eyes)
- ☐ Blurred Vision Distance
- ☐ Blurred Vision Near
- ☐ Distorted Vision (halos)
- ☐ Double Vision
- ☐ Floaters or Spots
- ☐ Fluctuating Vision
- ☐ Loss of Vision
- ☐ Loss of Side Vision

General Health Condition

- ☐ Fever
- ☐ Weight Loss
- ☐ Other Symptoms
- ☐ Cardiovascular (High Blood Pressure, etc)
- ☐ Ear. Nose, Throat
- ☐ Kidney Problem
- ☐ Gastrointestinal
- ☐ Respiratory (Asthma)
- ☐ Muscles, Bones, Joints
- ☐ Skin Problem
- ☐ Anxiety or Depression
- ☐ Neurological (Multiple Sclerosis)
- ☐ Blood/Lymph
- ☐ Allergic
- ☐ Endocrine (Thyroid, Diabetes)

Are you?

- ☐ Pregnant
- ☐ Nursing

Family History

- ☐ Amblyopia (Lazy Eye)
- ☐ Blindness
- ☐ Cataract(s)
- ☐ Color Blindness
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Strabismus (Crossed Eyes)
- ☐ Lupus
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Other _____