PATIENT HISTORY FORM

Patient Name _____ Date _____

Birth Date _____ Referred by _____

REVIEW OF SYSTEMS Do you currently have any of the following problems?		
		If YES, please explain (How long?, Hospitalization?)
1. **Do you have any allergies to any medication?**	☐Yes ☐No	
2. **Constitutional** (fever, weight loss, other)	☐Yes ☐No	
3. **Eyes** (glaucoma, cataract, Floaters, retina problems, other - please specify)	☐Yes ☐No	
4. **Ear / nose / mouth / throat** (hearing loss, sinus problems, sore throat)	☐Yes ☐No	
5. **Cardiovascular** (heart problems, chest pain, irregular heart beat, high blood pressure)	☐Yes ☐No	
6 **Respiratory** (asthma, shortness of breath, wheezing, coughing)	☐Yes ☐No	
7. **Gastrointestinal** (heartburn, abd. pain, diarrhea, vomiting)	☐Yes ☐No	
8. **Genitourinary** (urinary problems, blood in urine)	☐Yes ☐No	
9. **Integumentary** (skin rashes, excessive dryness)	☐Yes ☐No	
10. **Musculoskeletal** (muscle aches, joint pain, swollen joint Arthritis?)	☐Yes ☐No	
11. **Neurological** (numbness, weakness, headaches, paralysis)	☐Yes ☐No	
12. **Hematologic/Lymphatic** (blood disorders, leukemia, Lupus)	☐Yes ☐No	
13. **Allergic/Immunologic** (hay fever, allergies)	☐Yes ☐No	
14. **Endocrine** (thyroid problems, Diabetes etc)	☐Yes ☐No	
15. **Psychiatric** (depression, anxiety)	☐Yes ☐No	
16. **Cancer**	☐Yes ☐No	

Family and social history: Do any medical or eye diseases run in your family. If YES, Please note relationship to patient.

☐ Glaucoma _____
☐ Diabetes _____
☐ High blood pressure _____
☐ Macular degeneration _____
☐ *Other* _____
Comments: _____

Do you smoke? If YES, how much? ☐ Yes ☐ No
How much: _____
Drink alcohol? If YES, how much? ☐ Yes ☐ No
How much? _____

Physician's Signature: _____ *Date:* _____