PATIENT'S MEDICAL HISTORY WITH REVIEW OF SYSTEMS

Patient Name_____ Date_____

If pediatric patient, name of person completing form _____

HISTORY OF EYE PROBLEMS

1. What problem(s) are you having with your eyes? _____

_____

2. Have you ever had any eye problems, patching treatment or surgery? Please be specific with approximate dates and the doctor who treated you. _____

_____

3. When was your last eye exam? _____4. Who was the doctor or where? _____

5. Do you wear glasses? _____ If yes, for how long? _____

6. Do you wear contact lenses?_____ If yes, what brand? _____

RECENT EYE SYMPTOMS

YES	NO		YES	NO	
☐	☐	Blurred vision	☐	☐	Pain or soreness
☐	☐	Double vision	☐	☐	Excess tearing
☐	☐	Glare/Light sensitivity	☐	☐	Mucous discharge
☐	☐	Burning	☐	☐	Redness
☐	☐	Itching	☐	☐	Crossed eyes

FAMILY HISTORY (parents, grandparents, brothers, sisters, uncles or aunts)

YES	NO		YES	NO	
☐	☐	Blindness	☐	☐	Glaucoma
☐	☐	Retinal detachment	☐	☐	Macular Degeneration
☐	☐	Genetic eye disease (runs in the family)	☐	☐	Eye Patching Therapy
☐	☐	Amblyopia (lazy eye)	☐	☐	High Blood Pressure
☐	☐	Strabismus (crossed or wandering eye)	☐	☐	Diabetes

SOCIAL HISTORY

	YES	NO	
Do you smoke?	☐	☐	Hobbies_____
Do you drink alcohol?	☐	☐	Sports _____

PERSONAL MEDICAL HISTORY

YES	NO		YES	NO	
☐	☐	Frequent headaches	☐	☐	Lung disease
☐	☐	Asthma	☐	☐	Heart problems
☐	☐	Frequent ear infections	☐	☐	Fever or weight loss
☐	☐	Other ear, nose or throat problems	☐	☐	HIV or AIDS
☐	☐	Attention Deficit Disorder	☐	☐	Skin disease
☐	☐	Reading problems/Learning disability	☐	☐	Mental illness
☐	☐	Stomach or intestinal disease	☐	☐	Cancer
☐	☐	Neurologic (brain) problems	☐	☐	Diabetes
☐	☐	Blood disorder (anemia, etc.)	☐	☐	Arthritis
☐	☐	Kidney or urinary disease	☐	☐	High Blood Pressure
☐	☐	Genetic diseases in family	☐	☐	Autoimmune disease
☐	☐	High Cholesterol	☐	☐	Thyroid Problems

OTHER MEDICAL CONDITIONS

List any previous surgery, hospitalizations, major illnesses, or injuries (other than eye problems) in the last five years.

_____

Who is your primary care doctor_____

List all medications including eye drops _____

List all allergies to medications or circle none: NONE _____