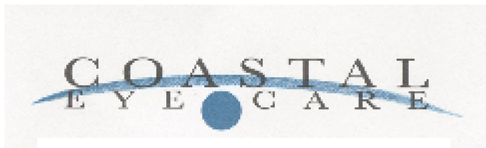

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PATIENT HISTORY RECORD

NAME: ____________________________ **DATE OF BIRTH:** ____________ **DATE COMPLETED:** _____________

Please answer the following questions about your medical status and history. Please use a separate piece of paper if necessary for lengthy explanations or lists of medications.

1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)
☐YES ☐NO If YES, please explain:______________________________

2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, etc.)
☐ YES ☐ NO If YES, please explain:______________________________

3. Have you ever had any surgery?
☐YES ☐NO If YES, please provide date and reason:______________________________

4. Have you ever been hospitalized?
☐YES ☐NO If YES, please provide date and reason:______________________________

5. Do you take any medications, vitamins or supplements?
☐YES ☐NO **If YES, please list on the "Medication List" form.**

6. Do you take any eye medications?
☐YES ☐NO If YES, please list:______________________________

7. Do you have any drug or food allergies?
☐YES ☐NO If YES, please list: ______________________________

REVIEW OF SYSTEMS

Do you currently have any of the following problems?			If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐ YES	☐ NO	______
Ear/nose/throat problems (hearing loss, sinus problems)	☐ YES	☐ NO	______
Heart problems (chest pain irregular heartbeat, etc.)	☐ YES	☐ NO	______
Respiratory problems (asthma, wheezing, coughing)	☐ YES	☐ NO	______
Gastrointestinal problems (heartburn, abdominal pain, diarrhea)	☐ YES	☐ NO	______
Urinary problems (pain or discomfort, blood in urine	☐ YES	☐ NO	______
Skin problems (rashes, excessive dryness)	☐ YES	☐ NO	______
Musculoskeletal problems (muscle aches, joint pain)	☐ YES	☐ NO	______
Neurologic problems (numbness, weakness, headaches)	☐ YES	☐ NO	______
Psychiatric problems (depression, anxiety)	☐ YES	☐ NO	______

FAMILY AND SOCIAL HISTORY

			If YES, please explain:
Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, glaucoma, cancer)	☐ YES	☐ NO	______
Have you ever been a smoker?	☐ YES	☐ NO	

Do you smoke currently? ☐ YES ☐ NO How much? ____________ How long? ____________

Do you drink alcohol? ☐ YES ☐ NO How much? ____________

TODAY'S DATE ________________ **PATIENT'S SIGNATURE** ______________________________
(or Responsible Party/Sponsor)

DATE REVIEWED ______________ **OPHTHALMOLOGIST'S SIGNATURE** ______________________

S:\FORMS & NEW PATIENT PACKETS\NPP\5 Patient History Record.docx

Please see other side or next attachment for: MedicationList.