

PATIENT HISTORY

NAME _____ SEX: M/F AGE _____ TODAY'S DATE _____

DO YOU HAVE PROBLEMS WITH:	IF YES, PLEASE EXPLAIN	NO
EYES (Example: eye injury, difficulty w/night driving, Reading in dim light, glare in sunlight)	_____	_____
GENERAL HEALTH (ex: fever, weight loss)	_____	_____
EARS, NOSE & THROAT (ex: dentures)	_____	_____
CARDIOVASCULAR (ex: heart disease, high blood pressure)	_____	_____
RESPIRATORY (ex: asthma, emphysema)	_____	_____
GASTROINTESTINAL (ex: hepatitis, ulcers)	_____	_____
GENITOURINARY (ex: kidney stones, kidney failure)	_____	_____
MUSCULOSKELETAL (ex: bones & joints)	_____	_____
ENDOCRINE (ex: thyroid, diabetes)	_____	_____
PSYCHIATRIC (ex: depression, anxiety)	_____	_____
NEUROLOGIC (ex: stroke, aneurysm)	_____	_____
BLOOD (ex: anemia, easy bleeder)	_____	_____
SKIN / BREAST (ex: rashes, breast cancer)	_____	_____
ALLERGIC / IMMUNOLOGIC (ex: HIV, Lupus)	_____	_____
ALL OTHER SYSTEMS NEGATIVE _____	_____	_____

CURRENT MEDICATIONS _____

ALLERGIES TO ANY MEDICATIONS (WHAT HAPPENS) _____

SIGNIFICANT PRIOR ILLNESSES AND OPERATIONS _____

ARE YOU CURRENTLY PREGNANT? YES _____ NO _____

DO YOU HAVE A FAMILY HISTORY OF DIABETES _____ CATARACTS _____ GLAUCOMA _____
HEART DISEASE _____ BLINDNESS _____ RETINAL DETACHMENT _____ KERATOCONUS _____

OCCUPATION (past or present) _____ USE TOBACCO? _____ ALCOHOL? _____ Rev'd by _____

DATE	DATE	DATE
Rev'd by _____	Rev'd by _____	Rev'd by _____

