The Eye Center

Patient Health History

Name:____________________ DOB: __________ Age: _____ Date: __________

Reason for Today's Visit: ____

Patients Eye History: None Glaucoma Cataracts Diabetic Eye Disease Halos Macular Degeneration Retina Problems Loss of Vision Flashes Floaters Lazy Eye Double Vision Blurred Vision Dry Eye(s) Eye Infection Eye Injury Eye Pain

Eye Surgery: ____________________ **Other Eye Diseases:** ____________________

Family Eye History: None Cataracts Diabetic Eye Disease Macular Degeneration Glaucoma Retina Problems Melanoma Loss of Vision

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CANCER: **Type:** ____

CARDIOVASCULAR: Hypertension Irregular Heartbeat Cardiac Valve Problems High Choleserol Disease Pacemaker Carotid Artery Blood Clots Defibrillator

ENDOCRINE: Diabetes Type 1 Diabetes Type 2 Thyroid Disease

RHEUMATOLOGICAL: Arthritis Lupus Ankylosing Spondylitis Temporal Arteritis

NEUROLOGICAL: Stroke Migraines Fainting Seizures

RESPIRATORY DISEASE: Asthma Sleep Apnea COPD Short of Breath Cough

KIDNEY/UROLOGICAL: Enlarged Prostate BPH Medication? ____________________

Are You Pregnant or Breast Feeding? No Yes

Other Medical Conditions: ____

Surgical History: ____

Allergy to Meds or Latex: None **List Allergies:** ______________________________

MEDICATIONS & DOSAGES (Including Eye Drops) ______________________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

SOCIAL HISTORY: **Smoker:** No Yes **Amount Per Day:** ____ **Alcohol:** No Yes **Amount:** _____

Pharmacy: __________ **Address:** ____________________ **Phone:** __________ **Fax:** __________

PCP: **Name:** __________ **Address:** ____________________ **Phone:** __________

Patient Signature: ____________________ **Date:** ____________________