

PATIENT HISTORY FORM

NAME _____ DOB _____ DATE _____

Chief Complain/Reason for my visit:
Location: Which Eye?
Quality: What are you experiencing?
Severity: How bad is it?
Duration: When did the problem start?
Timing: How long does it usually last?
Context: In what setting does it occur?
Modifying Factor: What makes it better or worse?
Associated Symptoms: Other symptoms that occur?
Treatments: How have you treated the problem?

Pharmacy Name: _____ Pharmacy ph#: _____

Pharmacy Location: _____

Referring Optometry _____ Primary Care Doctor _____

Do you have any allergies? No Yes

Please list _____

Do you use tobacco, alcohol or recreational drugs? No Yes

Please comment _____

Family Medical History – Does anyone in your family have the following?

Glaucoma Diabetes Cross Eyes Blindness Cancer Heart Disease None

Other _____

Please list names and doses of all medications you take:			
Medication	Dosage	Medication	Dosage
<input type="checkbox"/> None			

List all previous operations/ treatments/ injuries/ illnesses

Date	Description

Additional comments:

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REVIEW OF SYSTEMS

NAME _____ DOB _____ DATE _____

Please check those things which apply to you.

<p><u>Eyes</u></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/>Glasses <input type="checkbox"/>Contacts <input type="checkbox"/>Pain <input type="checkbox"/>Redness <input type="checkbox"/>Discharge <input type="checkbox"/>Tearing <input type="checkbox"/>Itching </div> <div style="width: 45%;"> <input type="checkbox"/>Swelling <input type="checkbox"/>Light Sensitivity <input type="checkbox"/>Floaters <input type="checkbox"/>Double Vision <input type="checkbox"/>Distortion <input type="checkbox"/>Loss of Color <input type="checkbox"/>NONE </div> </div>		
<p><u>Constitutional Problems</u></p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> NONE	<p><u>Cardiovascular</u></p> <input type="checkbox"/> Chest pain/ Angina <input type="checkbox"/> Heart Attack <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> NONE	<p><u>Endocrine</u></p> <input type="checkbox"/> Heat/ Cold Intolerance <input type="checkbox"/> Severe Thirst <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Infertility <input type="checkbox"/> NONE
<p><u>Skin and/ or Breast</u></p> <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Change in Skin Color <input type="checkbox"/> Loss of Hair <input type="checkbox"/> Breast Lumps/ Surgery <input type="checkbox"/> NONE	<p><u>Ear/Nose/Mouth/ Throat</u></p> <input type="checkbox"/> Ringing Ears <input type="checkbox"/> Difficulty Hearing <input type="checkbox"/> Difficulty Chewing <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Difficulty Speaking <input type="checkbox"/> Vertigo <input type="checkbox"/> NONE	<p><u>Gastrointestinal</u></p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea/ Vomiting <input type="checkbox"/> Liver Disease <input type="checkbox"/> Diarrhea/ Constipation <input type="checkbox"/> Passing Blood <input type="checkbox"/> Change in Stool Color <input type="checkbox"/> NONE
<p><u>Neurological</u></p> <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy <input type="checkbox"/> Headaches/ Migraines <input type="checkbox"/> Balance disturbances <input type="checkbox"/> Numbness of extremities <input type="checkbox"/> Tremors <input type="checkbox"/> NONE	<p><u>Musculoskeletal</u></p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Muscle Cramps/ Spasm <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Aching Joints <input type="checkbox"/> Swelling Joints <input type="checkbox"/> NONE	<p><u>Respiratory</u></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Productive Cough <input type="checkbox"/> Tuberculosis <input type="checkbox"/> NONE
<p><u>Genitourinary</u></p> <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Infections <input type="checkbox"/> Burning Urine <input type="checkbox"/> Genital Discharge <input type="checkbox"/> Dialysis <input type="checkbox"/> Altered Menstrual Cycle <input type="checkbox"/> NONE	<p><u>Psychiatric</u></p> <input type="checkbox"/> Memory Loss/difficulty <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Sleeplessness <input type="checkbox"/> Early Waking <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety Attacks <input type="checkbox"/> NONE	<p><u>Diabetes Controlled By</u></p> <input type="checkbox"/> Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Medication <input type="checkbox"/> NONE
		<input type="checkbox"/> HIV Positive <input type="checkbox"/> Cancer: _____ <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive