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**
□ **None**			

List all previous operations/ treatments/ injuries/ illnesses	
Date	**Description**

Additional comments:

REVIEW OF SYSTEMS

NAME_____**DOB**_____**DATE**_____

ADDRESS: _____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

PH/CELLULAR#: _____ **SOCIAL SECURITY:** _____

Please check those things which apply to you

Eyes

□Glasses □Redness □Itching □Floaters □Loss of Color
□Contacts □Discharge □Swelling □Double Vision □NONE
□Pain □Tearing □Light Sensitivity □Distortion

Constitutional Problems

□Fatigue
□Fever
□Weight Loss
□Loss of Appetite
□NONE

Cardiovascular

□Chest pain/ Angina
□Heart Attack
□Irregular Heartbeat
□Heart Murmur
□High Blood Pressure
□NONE

Endocrine

□Heat/ Cold Intolerance
□Severe Thirst
□Excessive Hunger
□Infertility
□NONE

Skin and/ or Breast

□Rashes
□Hives
□ Change in Skin Color
□Loss of Hair
□Breast Lumps/ Surgery
□NONE

Ear/Nose/Mouth/Throat

□Ringing Ears
□Difficulty Hearing
□Difficulty Chewing
□Difficulty Swallowing
□Difficulty Speaking
□Vertigo
□NONE

Gastrointestinal

□Abdominal Pain
□Indigestion
□Nausea/ Vomiting
□Liver Disease
□Diarrhea/ Constipation
□Passing Blood
□Change in Stool Color
□NONE

Neurological

□Stroke
□Epilepsy
□Headaches/ Migraines
□Balance disturbances
□Numbness of extremities
□Tremors
□NONE

Musculoskeletal

□ Arthritis
□ Muscle Cramps/ Spasm
□ Muscle Weakness
□Aching Joints
□Swelling Joints
□NONE

Respiratory

□Asthma
□Emphysema
□Shortness of Breath
□Productive Cough
□Tuberculosis
□NONE

Genitourinary

□Kidney Stone
□Infections
□Burning Urine
□Genital Discharge
□Dialysis
□Altered Menstrual Cycle
□NONE

Psychiatric

□Memory Loss/difficulty
□Poor Concentration
□Sleeplessness
□Early Waking
□Depression
□Anxiety Attacks
□NONE

Diabetes Controlled By

□Diet
□Insulin
□Oral Medication
□NONE

□Cancer: _____
□High Cholesterol
□HIV Positive