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: ____________________________

WEIGHT: ____________ HEIGHT: ____________

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
- □NONE
- □Heart Attack
- □Irregular Heartbeat
- □Heart Murmur
- □High Blood Pressure

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

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

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

FOR OFFICE USE ONLY

REVIEW OF SYSTEM/PHYSICAL EXAMINATION

WEIGHT: _________ HEIGHT: _________ AIR SaQ: _________ B/P: _________ P: _________ R: _________

AIRWAY

□ WNL □ CONTACT LENSES □ CHIPPED, BROKEN, LOOSE TEETH □ CAPS □PLATES □ BRIDGE □ DENTURES □ upper □ lower □ both

RISK ASSESSMENT:

APPROPIATE FOR AMBULATORY SURGICAL SETTING: ______________________________

VITAL SIGNS: WNL Yes _________ other ______________________________

HEART AND LUNGS CTA _________ other ______________________________

No changes or risks to procedure or anesthesia ______________________________

Other ____

PATIENT/GUARDIAN

- □ **Informed of Anesthetic** Options/Risk and Consents
- □ **Refused to Discuss** Anesthesia Options Risks
- □ **Anesthetic Risks/Options** Discussed with Guardian

NPD STATUS

MEDS

OTHER	NECK EXT	MP SCORE	AIRWAY PROBLEM □ NONE
PRE-ANESTHESIA STATE □ AWAKE □ CALM □ APPREHENSIVE □ UNCOOPERATIVE □CONFUSED □ ANXIOUS ASA			
SIGNATURE of date/time	CRNA SIGN	MD SIGN	

TIME: DATE: INITIALS: