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