PATIENT HISTORY FORM

NAME_____DOB_____DATE_____

Pharmacy name: _____ Pharmacy phone #: _____

Pharmacy location: _____

Referring Optometrist:_____ Primary Care Doctor:_____

Reason for visit:_____

Which eye: _____

When did the problem start? _____

Do you have any <u>allergies</u> to <u>medications</u>? □No □Yes

Please list: _____

Please list medication names and doses you take: □NONE

Medication	Dosage	Medication	Dosage

Previous eye surgeries or injuries (including date):_____

_____

Write down any eye drops you are currently taking:_____

_____

Medical History:

□ Anxiety
□ Arthritis
□ Asthma
□ Cancer --Type:_____
□ Epilepsy
□ Diabetes
□Type I □Type II □Insulin injection
□ Herpes (cold sore, shingles)
□ High cholesterol
□ Hypertension
□ Hypothyroidism
□ Depression
□ Migraines
□ Seasonal Allergies
□ Stroke
□ Other illness you have not listed above: _____

_____

PATIENT HISTORY FORM

NAME_____DOB_____DATE_____

Address: _____

Phone #: _____ Alternate Phone #: _____

Height: _____ Weight: _____ Social Security # _____

Prior surgery	Date of surgery	Prior Surgery	Date of surgery

Family History:

□ None □ Glaucoma □ Diabetes □Eye Turn □ Blindness □ Cancer □ Heart Disease

□Other: _____

Do you use tobacco? □No, never □No, former smoker □Yes

If yes, type of tobacco? _____ how often? _____

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

If yes please comment _____ how often? _____

Please check those things that apply to you today

Constitutional	**Cardiovascular**	**Metabolic/Endocrine**	**Skin**
□Fatigue □Fever □Weight Loss □NONE	□Chest pressure □Calf pain □Leg swelling □NONE	□Cold Intolerance □Heat Intolerance □Severe Thirst □Excessive Hunger □NONE	□Hives □Change in skin color □Skin lesions/sore □NONE
Ear/Nose/Mouth/ Throat	**Gastrointestinal**	**Neurological**	**Musculoskeletal**
□Hearing loss □Sore throat □Ringing Ears □Vertigo □NONE	□Abdominal Pain □Constipation □Diarrhea □Nausea □NONE	□Balance disturbances □Dizziness □Numbness of extremities □NONE	□Joint swelling □Muscle cramping □Muscle weakness □Swelling Joints □NONE
Respiratory	**Genitourinary**	**Psychiatric**	**Blood/Lymph**
□Asthma □Cough □Shortness of breath □NONE	□Painful urination □Genital lesions □Genital Discharge □NONE	□Emotional changes □Hallucinations □Sleeplessness □NONE	□Bleeding □Tender lymph nodes □NONE