PATIENT HISTORY

PATIENT NAME: _____ SEX (M/F) DATE: _____ BIRTH DATE_____

ADDRESS _____ CITY _____ STATE_____ ZIP_____

PHONE_____ LAST EYE EXAM DATE _____ PRIMARY PHYSICIAN_____
REQUEST COPY OF HIPPA GUIDELINES - Y/N (CIRCLE ONE)

PERSONAL MEDICAL INFORMATION (PATIENT ONLY). CHECK BOX IF YOU HAVE CONDITION

☐ CARDIOVASCULAR (heart, blood pressure,etc)	☐ EAR/NOSE/THROAT	☐ GASTROINTESTINAL(digestive,etc)
☐ RESPIRATORY(lung, etc)	☐ HEADACHES	☐ NERVOUS SYSTEM(stroke,etc)
☐ MUSCULOSKELETAL	☐ SKIN	☐ GENITOURINARY(bladder,etc)
☐ MENTAL/MOOD	☐ ENDOCRINE(diabetes,etc)	☐ BLOOD/LYMPH
☐ ALLERGIC/IMMUNOLOGIC	☐ SURGERIES	

ARE YOU ALLERGIC TO ANY MEDICATION OR OTHER SUBSTANCES ? YES/ NO (circle one)
If yes, please list:_____

OTHER FACTORS
DO YOU SMOKE? Y/N (circle one) DO YOU DRINK ALCOHOL? Y/N (circle one)
DO YOU USE ANY RECREATIONAL DRUGS? Y/N (circle one)
DO YOU TAKE MEDICATIONS ? Y/N (circle one)
LIST CURRENT MEDICATIONS (PRESCRIBED OR OTC):_____
_____

DO *YOU* HAVE ANY OF THESE EYE CONDITIONS?

☐ DRY EYES	☐ EYE SURGERIES	☐ EYE INJURIES	☐ MACULAR DEGENERATION	☐ CATARACTS
☐ BLURRED VISION	☐ WEAR GLASSES	☐ WEAR CONTACTS	☐ RETINAL DETACHMENT	☐ GLAUCOMA

DO YOU HAVE *FAMILY HISTORY* OF THESE EYE/MEDICAL CONDITIONS?

☐ EYE SURGERIES	☐ MACULAR DEGENERATION	☐ BLINDNESS	☐ DIABETES
☐ GLAUCOMA	☐ RETINAL DETACHMENT	☐ AMBLYOPIA (LAZY EYE)	☐ STROKE

MY SIGNATURE SERVES AS WRITTEN CONSENT TO DILATION, ANY NECESSARY MEDICAL TEST/TREATMENT AND OR CONTACT LENS FITTING (ELECTIVE). THIS CONSENT APPLIES TO PARENT/GUARDIAN OF MINOR CHILDREN.

SIGNATURE OF PATIENT_____ DATE_____
SIGNATURE OF PARENT/GUARDIAN (if applicable)_____ DATE_____

REVIEWED___/___/___ REVIEWED___/___/___ REVIEWED___/___/___ REVIEWED___/___/___ REVIEWED___/___/___