

# PATIENT HISTORY FORM

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## REVIEW OF SYSTEMS

(Do you currently have any of the listed problems? Please specify below.)

1. <b>Constitutional</b> (fever, weight loss, fatigue, other)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
2. <b>Eyes</b> (glaucoma, cataract, lazy eye, retina problems, floaters, other — please specify)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
3. <b>Ear/Nose/Throat</b> (hearing loss, chronic sinus problems, sore throat)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
4. <b>Cardiovascular</b> (high blood pressure, high cholesterol, irregular heartbeat)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
5. <b>Respiratory</b> (asthma, shortness of breath, wheezing, persistent cough)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
6. <b>Gastrointestinal</b> (heartburn, abdominal pain, vomiting, nausea, loss of appetite)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
7. <b>Genitourinary</b> (urinary problems, blood in urine, other)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
8. <b>Integumentary</b> (skin rashes, excessive skin dryness)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
9. <b>Musculoskeletal</b> (muscle aches, cramps, osteoarthritis, rheumatoid arthritis, gout)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
10. <b>Neurological</b> (numbness, weakness, paralysis, migraine headaches, seizures)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
11. <b>Hematologic/Lymphatic</b> (anemia, blood disorders, leukemia)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
12. <b>Allergic/Immunologic</b> (hay fever, environmental allergies)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
13. <b>Endocrine</b> (thyroid problems, diabetes)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
14. <b>Psychiatric</b> (depression, anxiety, memory loss, nervousness, insomnia)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
15. <b>To the best of your knowledge, do you have or have you been exposed to:</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C
16. <b>Do you have any allergies to medications?</b> (please specify)	<input type="checkbox"/> YES <input type="checkbox"/> NO	

**Family & Social History:** Do any medical or eye diseases run in your family? If YES, please note relationship.

- Glaucoma \_\_\_\_\_
- Diabetes \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Migraine Headaches \_\_\_\_\_
- Macular Degeneration \_\_\_\_\_
- Retinal Detachment \_\_\_\_\_
- Other \_\_\_\_\_

Do you smoke?     YES     NO

How much: \_\_\_\_\_

Do you drink alcohol?     YES     NO

How much: \_\_\_\_\_

**Past Medical History** (hospitalizations, illnesses, surgery):

When?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Provider  
Initials/Date