NAME:_____ **NICK NAME:** _____

OFFICE USE ONLY PLEASE

PMH SUMMARY

_____
_____
_____
_____
_____
_____
_____

PSH SUMMARY

_____
_____
_____
_____
_____
_____

POH SUMMARY

_____
_____

FAMILY HISTORY SUMMARY

_____
_____
_____

PAST OCULAR / EYE HISTORY:
List eye conditions, injuries and surgeries

_____ _____
_____ _____
_____ _____

LIST MEDICAL & SURGICAL HISTORY:

_____ _____
_____ _____
_____ _____
_____ _____

ARE YOU ALLERGIC TO LATEX ☐ Yes ☐ No

What do you do on a regular basis?

❑ Drive
❑ Word Puzzles
❑ Read Books / Magazines
❑ Golf ❑ Cook
❑ Sew/Needlepoint/Quilt
❑ Garden / Yard Work
❑ Childcare
❑ Other _____
❑ Computer work
❑ Read Newspaper
❑ Read Music
❑ Photography
❑ Carpentry / Auto
❑ Paint / charcoal drawings
❑ Scrap booking / card making

SOCIAL HISTORY:
Current Occupation _____
_____

Do you smoke? ❑ Yes ❑ No
If yes, for how long _____
How much: _____ pack[s] per day

LIST ALL CURRENT MEDICATIONS:
[Include vitamins / supplements]

_____ _____
_____ _____
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LIST CURRENT EYE DROPS:

_____
_____
_____
_____

LIST MEDICATION ALLERGIES:

_____ _____
_____ _____
_____ _____

OFFICE USE ONLY * * * PATIENT HISTORY REVIEW DOCUMENTATION * * * OFFICE USE ONLY

DATE:	SIGNATURE	DATE	SIGNATURE	DATE	SIGNATURE

Continue on other side please ⇨ ⇨ ⇨

FOR EVERY AREA BELOW INDICATE ALL PROBLEMS THAT YOU ARE EXPERIENCING OR TAKING MEDICATION FOR [MARK "NO PROBLEMS" IF YOU ARE NOT HAVING PROBLEMS]

General ☐ **NO PROBLEMS** ☐ Fever ☐ Weight Loss ☐ Cancer [location _____]
Other _____

Ears, Nose and Throat ☐ **NO PROBLEMS** ☐ Allergies / Hay Fever ☐ Sinusitis / Congestion
☐ Hearing Loss **Other** _____

Cardiovascular (Heart/Blood Vessels) ☐ **NO PROBLEMS** ☐ Chest Pain/Angina ☐ High Cholesterol
☐ Poor Circulation ☐ High Blood Pressure ☐ Stroke
☐ Heart Disease/Congestive Heart failure **Other** _____

Respiratory (Lungs/Breathing) ☐ **NO PROBLEMS** ☐ Asthma / Breathing Conditions
☐ Shortness of Breath / COPD **Other** _____

Gastrointestinal (Stomach/Intestines) ☐ **NO PROBLEMS** ☐ Digestive Problems ☐ Acid Reflux
Other _____

Genitourinary (Genitals/Kidney/Bladder) ☐ **NO PROBLEMS** ☐ Stress Incontinence ☐ Frequent Bladder Infections
Other _____

Musculoskeletal ☐ **NO PROBLEMS** ☐ Back Pain ☐ Arthritis ☐ Sciatica ☐ Fibromyalgia
Other _____

Integumentary (Skin/Breast) ☐ **NO PROBLEMS** ☐ Skin Rash/Psoriasis ☐Skin Disorders
Other _____

Neurological ☐ **NO PROBLEMS** ☐ Headaches ☐ Migraines
☐Alzheimer's/Dementia ☐ Parkinson's disease ☐ Multiple Sclerosis
Other _____

Psychiatric ☐ **NO PROBLEMS** ☐ Depression ☐ Anxiety ☐ Bipolar
Other _____

Endocrine ☐ **NO PROBLEMS** ☐ Thyroid: High Low ☐ Diabetes: Year Diagnosed ____
Other _____

Hematological/Lymphatic ☐ **NO PROBLEMS** ☐ Bleeding Tendencies ☐ Lymph Node Swelling
☐ Anemia **Other** _____

Immunologic ☐ **NO PROBLEMS** ☐ Immune Disorder ☐ Lupus ☐ Sjogrens
Other _____

Have you or any family member been told you have any of the following eye / medical conditions? If YES please mark the corresponding box.

Condition	Self	Family	If Family checked, please list their relationship to you
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Cataracts	☐	☐	_____
Lazy/Crossed Eyes	☐	☐	_____
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Stroke	☐	☐	_____
Heart Disease	☐	☐	_____
Cancer	☐	☐	_____
Other	☐	☐	_____

Patient / Legal Guardian Signature _____ **Date**_____

Physician's / Reviewers Signature _____ **Date** _____