

PATIENT

HISTORY

SHEET

PLEASE ANSWER THE FOLLOWING QUESTIONS CONCERNING YOUR MEDICAL HISTORY

Name: _____ DOB: _____

Date of Last Eye Exam _____

The eye doctor seen was an _____ Ophthalmologist
_____ Optometrist

FOOD OR DRUG ALLERGIES	CURRENT MEDICATIONS

LIST PREVIOUS EYE SURGERIES, INJURIES, OR DISEASES YOU HAVE HAD

SURGERY, INJURY OR DISEASE	DATE

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

	YES	NO	PLEASE EXPLAIN
DIABETES			
HYPERTENSION			
HEART DISEASE			
KIDNEY DISEASE			
BLEEDING DISORDER			
OTHER			

FAMILY HISTORY: DOES ANY BLOOD RELATIVE OF YOURS HAVE:

	YES	NO		YES	NO	
CATARACTS				GLAUCOMA		
RETINAL DETACHMENT				CROSSED EYES		
BLINDNESS				DIABETES		
HEART ATTACKS				BLEEDING DISORDER		
OTHER						

DO YOU NOW HAVE OR HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING PROBLEMS WITH YOUR EYE(S)?

	YES	NO		YES	NO	
LIGHT SENSITIVITY				DOUBLE VISION		
REDNESS				DISTORTED VISION		
FLASHING LIGHTS				LOSS OF VISION		
FLOATERS				DECREASED FAR VISION		
ITCHINESS				DECREASED NEAR VISION		
SCRATCHINESS				DRYNESS		
TROUBLE FOCUSING				DISCHARGE		
PAIN				GLARE		
HEADACHE						