Patient History Record

Name:____ Date:____________________

Reason for This Visit:____

History of This Condition:____

____

For patients 3 years of age or younger:
Birth weight _________ Premature? _________ (If so, how many weeks? _________)
During pregnancy… Any ILLNESSES? _______________ any MEDICINES? _______________ any X-RAY? _________________
DUring delivery…any complications? _________ During hospital stay…any complications? ________________________________
During the baby's life, how has the baby's general development been? ____

Please answer the following questions about your (the patient) medical status and history:

1. Have you ever been treated for any **MEDICAL CONDITIONS**? (e.g., DIABETES, HIGH BLOOD PRESSURE, arthritis, heart, kidney, or thyroid)
   Yes / No If yes, explain:____
2. Have you ever had any **EYE DISEASE**? (e.g., GLAUCOMA, CATARACT, wandering or "lazy" eye, retinal detachment)
   Yes / No If yes, explain:____
3. Have you ever had any **EYE** or other **SURGERY**?
   Yes / No If yes, DATE & REASON:____
4. Have you ever been **HOSPITALIZED**?
   Yes / No If yes, DATE & REASON:____
5. Do you take any **MEDICINES**? Yes / No
   If yes, list all medications you are currently taking:_______________________________
6. Do you use any **EYE MEDICINES**? Yes / No
   If yes, list all medications you are currently taking:_______________________________
7. Do you currently or have you ever:
   Worn glasses? _________ Contacts? _________ Had eye exercise?_________ Had eye patching?_________

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Review of Systems	**Yes**	**No**	**If yes, explain**
Do you currently have any of the following problems:			
Chronic fever, unexpected weight loss / gain, fatigue	☐	☐	
Ear / nose / throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pains, diarrhea, vomiting)	☐	☐	
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g.,rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	

Family and Social History

Do any medical or eye diseases run your family? (e.g., DIABETES, HIGH BLOOD PRESSURE, cancer, heart disease, bleeding problems, BLINDNESS, CROSSED EYES, LAZY EYE, CATARACT, GLAUCOMA, MACULAR DEGENERATION)

Yes / No If yes, please list disease and relation:____

Do you smoke?	Yes / No	Do you drink alcohol?	Yes / No
If not, are you a former smoker?	Yes / No	Do you use recreational drugs?	Yes / No

List any other information that may be helpful to the doctor:____

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