Patient History Form

Name_____ **Please mark all that apply**

Eye history

Glaucoma	O Yes	O No	Excess Tearing/ Watering	O Yes	O No
Cataract	O Yes	O No	Eye Pain Or Soreness	O Yes	O No
Macular Degeneration	O Yes	O No	Foreign Body Sensation	O Yes	O No
Retinal Degeneration	O Yes	O No	Infection Of Eye	O Yes	O No
Color blindness	O Yes	O No	Itching	O Yes	O No
Headaches	O Yes	O No	Mucous Discharge	O Yes	O No
Light Sensitivity	O Yes	O No	Drooping Eyelid	O Yes	O No
Amblyopia (lazy eye)	O Yes	O No	Redness	O Yes	O No
Loss of Central Vision	O Yes	O No	Sandy Or Gritty Feeling	O Yes	O No
Dryness	O Yes	O No	Diabetic Retinopathy	O Yes	O No
Blurred Vision	O Yes	O No	Dry Eye Syndrome	O Yes	O No
Double Vision	O Yes	O No	Strabismus (Eye Turn)	O Yes	O No
Loss Of Vision	O Yes	O No	Floaters Or Spots	O Yes	O No
Eye Injuries	O Yes	O No	High Risk Medication	O Yes	O No
Ocular Allergies	O Yes	O No			

General Health Condition

Pregnant	O Yes	O No	Muscles, Bones,Joints	O Yes	O No
Fever	O Yes	O No	Headaches	O Yes	O No
Weight Loss	O Yes	O No	Neurological Problems	O Yes	O No
Asthma	O Yes	O No	Thyroid	O Yes	O No
Cardiovascular	O Yes	O No	Diabetes	O Yes	O No
High Blood Pressure	O Yes	O No	Kidney Problems	O Yes	O No
High or Low Cholesterol	O Yes	O No	Acid Reflux	O Yes	O No
Triple By-Pass	O Yes	O No	Diarrhea	O Yes	O No
Depression	O Yes	O No	Urinary problems	O Yes	O No
Anxiety	O Yes	O No	AIDS/HIV	O Yes	O No
ADHD	O Yes	O No	Seasonal Allergies	O Yes	O No

Family History

Arthritis	O Yes	O No	Amblyopia (Lazy Eye)	O Yes	O No
Cancer	O Yes	O No	Blindness	O Yes	O No
Diabetes	O Yes	O No	Cataracts	O Yes	O No
Heart Disease	O Yes	O No	Color Blindness	O Yes	O No
High Blood Pressure	O Yes	O No	Glaucoma	O Yes	O No
Kidney Diseaese	O Yes	O No	Macular Degeneration	O Yes	O No
Lupus	O Yes	O No	Eye Tumors	O Yes	O No
Stroke	O Yes	O No	Retinal Detachment	O Yes	O No
Thyroid Disease	O Yes	O No	Strabismus (Eye Turn)	O Yes	O No