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PATIENT HISTORY Inventory

please complete both sides of this form

Visit Date: _______________ Referred By: _________________________Referral Phone: __________________

Date of Birth: ___________________________ Age: ______________

Patient Name: ____ Primary Care Physician: ___________________

Legal Guardian Name & Relationship *(if patient is a minor)*: ____

Current Occupation: ____

EYE Medications: ☐ None Taken or ☐ See attached List *(or list below)*

Name	Dosage	Frequency	Reason for

Medications: ☐ None Taken or ☐ See attached List *(or list below)*

Name	Dosage	Frequency	Reason for

Usual PHARMACY Name & Location: ____

Allergies: ☐ None Known ☐ Latex
Drugs: ____

Do you wear GLASSES/CONTACTS for ☐ Distance ☐ Reading ☐ both *(Please bring your glasses with you)*

Do you wear CONTACTS *(check all that apply)*

☐ Daily Wear ☐ Extended Wear ☐ Hard ☐ Soft ☐ Gas Perm

☐ Glaucoma ☐ Lazy Eye ☐ Injury ☐ Macular Degeneration ☐ Cataract

Reviewed:____ Date:________________________________

Reviewed:____ Date:________________________________

List Others Below

Eye Surgery, Event or Disease	R Eye	L Eye	Date
______	☐	☐	______
______	☐	☐	______

Illnesses

☐ Diabetes
☐ Heart Disease
☐ Asthma
☐ High Blood Pressure
☐ Emphysema
☐ Stroke
☐ Cancer
☐ Arthritis
☐ COPD
☐ High Cholesterol
☐ CHF

Family History							
	Y	N	**Relationship to Patient** **M**other, **F**ather, **S**ibling, **G**randparent		Y	N	**Relationship to Patient** **M**other, **F**ather, **S**ibling, **G**randparent
Blindness				Heart Disease			
Glaucoma				High BP			
Arthritis				Kidney Disease			
Cancer				Lupus			
Diabetes				Stroke			
Cataracts				Macular Degeneration			

Review of Systems	Y	N	If YES, please explain
General/Constitutional (fever, weight loss, obesity, etc)			
Integumentary/Skin (rashes, growths, hair loss, etc)			
Ears (hearing loss, drainage, etc)			
Neck (swollen glands, thyroid, etc)			
Respiratory (congestion, wheezing, COPD, etc)			
Cardiovascular (high BP, racing pulse, etc)			
Gastrointestinal (stomach upset, diarrhea, constipation, etc)			
Genitourinary (painful or frequent urination, impotence, etc)			
Muscular Skeletal (joint pain, stiffness, swelling, cramps, etc)			
Neurological (seizures, convulsions, numbness, headache, weakness, etc)			
Endocrine (bruising, diabetes, hypothyroid, etc)			
Hematology-Immunologic (anemia, high cholesterol, bleeding tendencies, etc)			
Psychiatric (anxiety, depression, insomnia)			

Do you drink alcohol? ☐ No — If yes ☐ occasionally ☐ 1/day ☐ 2-3/day ☐ 4+/day
Do you use tobacco? ☐ No — If yes ☐ Chewing ☐ 1 pack /day ☐ 1+pack/day

______________________________ ______________________________

Signature Date

Reviewed:______________________________ Date:______________________________
Reviewed:______________________________ Date:______________________________