# PATIENT HISTORY FORM

**NAME:** ________________________________________ **DOB:** ____/_______/_____

**Email**: ______________________________________________________________

**Occupation (Job)**:_____________________________________________________

**Medications**: (Provide list to staff)_________ ________________________ ***If none, check here*** ☐

______________________________________________________________________

______________________________________________________________________

**Allergies to medications:** ______________________________________ ***If none, check here*** ☐

***PLEASE CIRCLE ALL THAT APPLY TO YOU BELOW***

**PATIENT EYE HISTORY:**

***Contact Lenses***

***Glasses***

Cataract*: Right eye Left eye

Allergic Conjunctivitis (pink eye)

**Dry eyes**

Glaucoma*

Macular degeneration*

Retinal tear or detachment*

Strabismus (eye turn)

Floaters: Right Eye Left Eye

**PATIENT EYE SURGERY:**

Cataract Surgery*

Eye muscle surgery

Retina laser*

LASIK: Right Eye Left Eye

Diabetic eye surgery*

**FAMILY HISTORY (Parent, Grandparent, or sibling)**

| | |
|---|---|
| Blindness* | Heart Disease* |
| Cancer | Hypertension (High Blood Pressure) * |
| Cataracts* | Macular Degeneration* |
| CVA (Stroke) | Migraine* |
| Diabetes* | Retinal Detachment* |
| Glaucoma* | Strabismus (eye turn) |

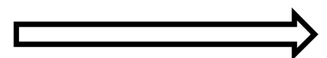
## Smoking status

1. Current every day smoker* ☐
2. Current some day smoker* ☐
3. Former smoker * ☐
4. Never smoker ☐

**Alcohol use**

1. None ☐
2. Less than one drink per day ☐
3. One-two drinks per day ☐
4. Three or more drinks per day* ☐

**CONTINUED ON BACK**



**REVIEW OF SYSTEMS** ***PLEASE CHECK ALL THAT APPLY TO YOU***

- ☐ Poor vision (with **OR** without glasses)
- ☐ Eye pain
- ☐ Tearing
- ☐ Increased sensitivity to bright light
- ☐ Eye redness
- ☐ Jaw pain (when chewing)
- ☐ Scalp tenderness
- ☐ Loss of vision* (complete loss either temporarily or permanently)
- ☐ High cholesterol* (or controlled with medications)
- ☐ High blood pressure* (or controlled with medications)
- ☐ **Diabetes*:**
  What year were you diagnosed _______ What was your last HbA1C _______
- ☐ Thyroid disease* ***(Please circle below if example given)***
- ☐ Respiratory problems (asthma, COPD, coughing, wheezing, etc.)
- ☐ Psychiatric problems (anxiety, depression, insomnia, etc.)
- ☐ Skin problems (rashes, dryness, rosacea, changing moles, etc.)
- ☐ Ear/Nose/Throat problems (sore throat, sinus, hearing loss, etc.)
- ☐ Unexplained or sudden weight loss
- ☐ Musculoskeletal problems (arthritis, joint pain, etc.)
- ☐ Autoimmune disease* (Crohn's, Lupus, MS, etc.)
- ☐ Headaches
- ☐ Migraines*
- ☐ Neurological problems* (numbness, weakness, paralysis, etc.)
- ☐ Genitourinary problems (pain, blood in urine, change in frequency of urination)
- ☐ Hematologic/lymphatic disease* (anemia, bleeding problems, etc.)
- ☐ Gastrointestinal problems
- ☐ Currently pregnant or nursing
- ☐ Seasonal allergies/hives

***PLEASE CHECK THIS BOX IF NONE OF THE ABOVE APPLY*** ☐

*** SMOKING, DIABETES, CATARACTS, HIGH BLOOD PRESSURE/CHOLESTEROL, GLAUCOMA, MACULAR DEGENERATION, HEART DISEASE, MIGRAINES

**If you selected any option on this form with a *star* it is important that you read this:**

We are now able to offer the **iWellness retinal scan**. It's a fast, simple procedure that gives the doctor detailed information about your eye health that isn't available from a traditional exam. Many disorders threaten your eye health without a vision. Based on your family and/or medical history, we strongly recommend the iWellness scan. **Other clinics charge $140** for a retinal scan; we can provide a

**significant discount**:***Total out of pocket cost $39**

**YES, I WOULD LIKE THIS SCAN TODAY** ☐ **No thank you** ☐