PATIENT HISTORY SHEET

Name_____ Age_____ Date_____

Primary Care Physician/PCP _____

Personal History/Social History

Do you smoke	Yes	No
Illnesses: (circle all answers)		
Have you ever had:		
Pneumonia	Yes	No
Rheumatic Fever	Yes	No
Heart Disease	Yes	No
Polio or Meningitis	Yes	No
Gonorrhea or Syphilis	Yes	No
Gallbladder Disease	Yes	No
Anemia	Yes	No
Jaundice	Yes	No
Bladder Disease	Yes	No
Epilepsy	Yes	No
Tuberculosis	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Any Drug Habits	Yes	No
Asthma	Yes	No
Frequent Infection	Yes	No
Boils	Yes	No
Hay Fever	Yes	No
Chest Pain (angina)	Yes	No
Pain in Arm(s)	Yes	No
Chronic Cough	Yes	No
Shortness of Breath	Yes	No
Palpitations (fluttering) of the Heart	Yes	No
Swelling of Hands, Feet or Ankles	Yes	No

If so, at what time of day_____

Leg cramps while walking or at night	Yes	No
Vomited Blood	Yes	No
Any Blood in Stool	Yes	No
Backaches	Yes	No
Muscle Spasms	Yes	No
Easy Bruising	Yes	No
ALLERGIES: ARE YOU ALLERGIC TO:		
Any Anesthesia	Yes	No
Penicillin	Yes	No
Aspirin, Codeine, or Morphine	Yes	No
Mycins or other Antibiotics	Yes	No
Merthiolate or Mercurochrome	Yes	No
Eye Medications	Yes	No
Adhesive Tape	Yes	No
Rubber	Yes	No
Latex	Yes	No
Tetanus Antitoxin or Serums	Yes	No
Local Anesthetic	Yes	No
Sulfa	Yes	No
Any other Drug Allergies?	Yes	No

Please list:_____

_____

_____

Surgical History:

Any Eye Surgery	Yes	No
Transfusions: Have you ever had:		
Blood or Plasma Transfusions	Yes	No
Surgery: Have you had:		
Tonsillectomy	Yes	No
Appendectomy	Yes	No
Any other operation	Yes	No

Type:_____ Year_____

Type:_____ Year_____

Type:_____ Year_____

Type:_____ Year_____

OCULAR HISTORY

Do you now have or have you had within the past year:

Migraine	yes	no
Frequent Headache	yes	no
Dizziness	yes	no
Lazy or weak eye	yes	no
Loss of consciousness	yes	no
Blurred Vision	yes	no
Double Vision	yes	no
Loss of Vision	yes	no
Spots before your eyes	yes	no
Infected eyes	yes	no
Pain behind the eyes	yes	no
Any change in vision	yes	no
Do you wear glasses?	yes	no
Eye Injury	yes	no

When were you last checked?

_____

FAMILY HISTORY

Has any blood relative ever had:

Cancer	yes	no
Tuberculosis	yes	no
Diabetes	yes	no
Heart Trouble	yes	no
High Blood Pressure	yes	no
Stroke	yes	no
Epilepsy	yes	no
Cataracts	yes	no
Glaucoma	yes	no
Retinal Disease	yes	no
Blindness	yes	no

Have you been hospitalized for any illness? yes no

Please give details for any "yes" answers above: _____

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you take aspirin? yes no

If yes, how often? _____