

PATIENT HEALTH HISTORY

Patient's Name:	Date:	
Date of birth :	Date of last physical exam :	Date of last eye exam :
List all medications you currently take (prescription and over-the-counter):		
Do you have known allergies to any medications? YES NO If YES please list:		
List all eye diseases (glaucoma, diabetic retinopathy, cataracts, etc.) or eye injuries (car accidents, metal in the eye, etc.):		
List any surgeries you have had (cataract, tonsillectomy, appenedectomy, etc.):		

Do you **currently** have any problems in the following areas?

EYES	YES	NO	EYES	YES	NO
Loss of vision			Itching		
Blurred vision			Burning		
Fluctuating vision			Foreign Body Sensation		
Distorted vision			Glare (halos) or light sensitivity		
Loss of side vision			Excess tearing or watering		
Double vision			Eye pain or soreness		
Tired eyes			Infection of eye or eyelid		
Crossed eye, lazy eye			Mucous discharge		
Drooping eye lid			Dryness		
Floaters			Sandy or gritty feeling		
Flashes of Lights			Redness		

If this examination is for a school age child please answer the following questions:

	YES	NO
Does your child complain of headaches at school?		
Does your child lose his/her place while reading?		
Do words run together when your child reads?		
Does your child report eye strain when reading?		
Has an involuntary eye turn been observed?		

Please turn over and complete the other side

History reviewed (For doctor use only)			
Dr. 's Signature _____	Date / / _____	Dr. 's Signature _____	Date / / _____
Dr. 's Signature _____	Date / / _____	Dr. 's Signature _____	Date / / _____
Dr. 's Signature _____	Date / / _____	Dr. 's Signature _____	Date / / _____
Dr. 's Signature _____	Date / / _____	Dr. 's Signature _____	Date / / _____
Dr. 's Signature _____	Date / / _____	Dr. 's Signature _____	Date / / _____

