

Patient History Record *Please complete all items*

Name _____ Date _____

Do you wear eyeglasses? Yes ___ No ___ Do you wear contact lenses? Yes ___ No ___

List any prescriptive medications that you are taking, including eye medications: _____

Are you allergic to any medication? Yes ___ No ___ If yes, please list: _____

Do you have: Diabetes? Yes ___ No ___ High blood pressure? Yes ___ No ___
Asthma? Yes ___ No ___ Emphysema? Yes ___ No ___
Thyroid disease? Yes ___ No ___ Heart disease? Yes ___ No ___
Any other ailments? Yes ___ No ___ If yes, please list: _____

Have you previously been diagnosed with: Glaucoma? Yes ___ No ___
Cataracts? Yes ___ No ___
Macular degeneration? Yes ___ No ___
Retinal detachment? Yes ___ No ___
Amblyopia? Yes ___ No ___
Strabismus? Yes ___ No ___

Have you ever had any previous eye laser or eye surgery? Yes ___ No ___ If yes, please describe: _____

Are there members of your family with: Glaucoma? Yes ___ No ___ Don't know ___
Retinal detachment? Yes ___ No ___ Don't know ___
Macular degeneration? Yes ___ No ___ Don't know ___
Diabetes Yes ___ No ___ Don't know ___

Do you have any of the following problems? If yes, please explain:

Chronic fever, unexpected weight loss or gain? Yes ___ No ___ _____
Hearing loss, sinus problems, sore throat? Yes ___ No ___ _____
Chest pain or irregular heart beat? Yes ___ No ___ _____
Shortness of breath, wheezing or coughing? Yes ___ No ___ _____
Heartburn, abdominal pain, diarrhea, vomiting? Yes ___ No ___ _____
Pain or discomfort when urinating, blood in urine? Yes ___ No ___ _____
Skin rashes? Yes ___ No ___ _____
Muscle aches, joint pain or swelling? Yes ___ No ___ _____
Numbness, weakness, headaches, paralysis? Yes ___ No ___ _____
Depression or anxiety? Yes ___ No ___ _____

Do you smoke? Yes ___ No ___ If yes, _____ packs per day for _____ years

Do you drink alcohol? Yes ___ No ___ If yes, _____ drinks per week

If employed, how many hours do you work each week? _____