THE REGIONAL EYE CENTER®
Always looking ahead.

PATIENT HISTORY RECORD

Name_____ Date_____

Birth Date _____ Sex _____ Age_____

Occupation/ Hobbies/ Interests _____

Referred by _____ Family Doctor _____

Please answer the following medical history questions:

1. Have you ever been treated for any medical conditions? (Heart disease, high blood pressure, diabetes, lung disease, stroke, etc.) Yes ☐ No ☐ If YES, please explain:

_____

_____

_____

2. Have you ever had any eye disease, eye surgery or eye injury? Yes ☐ No ☐ If YES, what kind and when:

_____

_____

3. Have you EVER had ANY other surgery? Yes ☐ No ☐ If YES, what kind and when:

_____

_____

4. Do you take any eye medications? Yes ☐ No ☐ If YES, please list:

_____

_____

5. Do you take any other medications? Yes ☐ No ☐ If YES, please list:

_____

_____

6. Do you have any drug allergies? Yes ☐ No ☐ If YES, please list:

_____

_____

PLEASE SEE OTHER SIDE

Review of Systems

Do you currently have any of the following problems?	Yes	No
1. Chronic fever, unexplained weight loss/gain, fatigue	☐	☐
2. Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐
3. Heart problems (e.g., chest pain, irregular heart beat)	☐	☐
4. Breathing problems (e.g., shortness of breath, wheezing, coughing)	☐	☐
5. Stomach or intestinal problems (e.g., heartburn, diarrhea, vomiting)	☐	☐
6. Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐
7. Skin Problems (e.g., rashes, excessive dryness)	☐	☐
8. Muscle or bone problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐
9. Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐
10. Psychiatric problems (e.g., depression, anxiety)	☐	☐

Explanation of above _____

_____

_____

Family and Social History

1. Do any medical or eye diseases run in your family? (Cataracts, glaucoma, macular degeneration, diabetes, etc.) Yes ☐ No ☐ If YES, please explain:

   _____

2. Do you smoke? Yes ☐ No☐ If YES, how much and for how long? _____

   _____

3. Do you drink alcohol? Yes ☐ NO ☐ If YES, how much? _____

4. Have you used any illegal drugs? Yes ☐ No ☐ If YES, what kind of drugs? _____

   _____. Are you currently using the drugs? Yes ☐ No ☐

   (Information is confidential and only used in your medical care.)

5. If employed, how many hours per week do you work?_____

Updates:_____

_____

_____

Staff reviewed _____

Date_____