Eye Specialists

PATIENT HISTORY RECORD

Date | Referred By | Birth Date

Patient Name | Sex | Age

Address | Phone (home) | Phone (cell)

Primary Care Physician

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)?

   Yes ___ No ___ If YES, please explain: _____

   _____

2. Do you have sleep apnea? Yes ___ No ___

3. Do you an implanted cardiac defibrillator? Yes ___ No ___

4. Have you ever had any eye disease (e.g., glaucoma, cataracts, wandering or “lazy” eye, retinal detachment)?

   Yes ___ No ___ If YES, please explain: _____

   _____

5. Have you ever had any surgery?

   Yes ___ No ___ If YES, please explain: _____

   _____

6. Have you ever been hospitalized?

   Yes ___ No ___ If YES, please explain: _____

   _____

7. Do you take any medications?

   Yes ___ No ___ If YES, please list: _____

   _____

   Do you take any eye medications?

   Yes ___ No ___ If YES, please list: _____

8. Do you have any drug allergies or a latex allergy?

   Yes ___ No ___ If YES, please list: _____