

Patient History

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Please print clearly.

Name

Date of Birth

Date

LIST CURRENT MEDICATIONS

ALLERGIC/IMMUNOLOGIC

Reactions	Yes	No	Name of Medicine	Type of Reaction
Reactions to antibiotics	☐	☐		
Narcotics	☐	☐		
Anesthetics	☐	☐		
Pain Remedies	☐	☐		
Vaccines	☐	☐		
Antiseptics	☐	☐		
Other Medicines	☐	☐		
Food allergies	☐	☐		

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MAJOR ILLNESSES-INJURIES

Year	Type of illness/injury

SURGERIES

Year	Type of surgery

EYE CONDITIONS AND SOCIAL HISTORY

Underline any that are applicable: crossed eyes, lazy eye, drooping eyelid, prominent eye

☐ Crossed eyes ☐ Lazy eye ☐ Drooping eyelid ☐ Prominent eye

Explain if appropriate

Do you drink if so how much?

Smoke? How much?

Ever had blood transfusion? ☐ Yes ☐ No

Contact with sexually transmitted disease ☐ Yes ☐ No

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FAMILY HISTORY

Your family history (parents, grandparents, brother, sister only) *if grandparent: mom's mom-dad, dad's mom-dad

Blindness	☐ yes	☐ no		Lupus	☐ yes	☐ no	
Cataract	☐ yes	☐ no		Sjogren's Syndrome	☐ yes	☐ no	
Glaucoma	☐ yes	☐ no		Stroke	☐ yes	☐ no	
Macular degeneration	☐ yes	☐ no		Thyroid disease	☐ yes	☐ no	
Retinal detachment	☐ yes	☐ no		Tuberculosis	☐ yes	☐ no	
Kidney disease	☐ yes	☐ no		Other			
Arthritis	☐ yes	☐ no					
Cancer	☐ yes	☐ no					
Diabetes	☐ yes	☐ no					
Heart attack	☐ yes	☐ no					
High blood pressure	☐ yes	☐ no					