PATIENT HISTORY SHEET

NAME _____ **DATE** _____

General History	Y	N	Review of Systems	Y	N	Ocular History	Y	N
Arthritis			Floaters & Flashes			Cataracts		
Asthma			Poor Vision			Cataract Surgery		
Cancer/type			Eye Pain			YAG Laser		
Diabetes			Tearing			Glaucoma		
Heart Disease			Redness			Retinal Diseases		
Hepatitis			Fever			LASIK		
High Blood Pressure			Chills					
High Cholesterol			Cough			**Family History**	**Y**	**N**
Kidney Disease			Wheezing			Diabetes		
Lung Disease			Shortness of Breath			Glaucoma		
Migraine Headaches			Joint Pain			Heart Disease		
Stroke			Thyroid disorder			Macular Degeneration		
Thyroid Disease			Anemia					
TB			Hay fever					
HIV/Syphilis								

SURGERIES: _____

MEDICATIONS: (Please provide the name of any medications you are currently using or attach a list)

_____ _____ _____

_____ _____ _____

Are you Allergic to any medications? _____

Do you Smoke? **YES** **NO** **Primary Care Physician:** _____

Do you drink Alcohol? **YES** **NO** **Pharmacy:** _____

RELEASE OF HEALTH INFORMATION: (please note: we will not discuss or disclose information with spouse/children if their name is not listed here)

Who may we release your health information or records to? _____

Relationship: _____

_____ _____

Signature of Patient ***Date***