Comprehensive Patient History

Today's Date ___ /____/_____

Patient Name: _____ Date of Birth ____/____/_____

Do you have any allergies to medications: Y N If yes, explain_____ Last Eye Exam: _____

List any medications you take: _____

_____ Are you pregnant? Y N

Ocular Review of Systems: ***Past History:***

Do you currently or have you ever had?

Blurred Vision	Y	N	Eye Infections	Y	N
Dry Eyes	Y	N	Cataracts	Y	N
Itchy Eyes	Y	N	Glaucoma	Y	N
Eye Discharge	Y	N	Macular Degeneration	Y	N
Tearing	Y	N	Retinal Detachments	Y	N
Floating Spots	Y	N	Lazy Eye	Y	N
Flashing Lights	Y	N	Eye Surgery	Y	N

Please give details for all "yes"_____
_____

Contact Lens Questions:

Are you interested in contact lenses?	Y	N
Have you ever worn contacts?	Y	N
Do you now wear contacts?	Y	N
What type? _____		
How long have you had this pair? _____		
Are you happy with your current lenses?	Y	N
Are you interested in trying a new lens?	Y	N
Are you interested in extended wear lenses?	Y	N

How many times per month do you sleep/nap in your contact lenses?_____

***Family History*:** Please note any family members (parents, grandparents, siblings, children) with any of these conditions

Blindness	Y	N	Who: _____	Macular Degeneration	Y	N	Who: _____
Glaucoma	Y	N	Who: _____	Retinal Detachment	Y	N	Who: _____
Cataracts	Y	N	Who: _____	High Blood Pressure	Y	N	Who: _____
Diabetes	Y	N	Who: _____	Cancer	Y	N	Who: _____

***Social History*:** This information is kept strictly confidential. If you prefer, you may discuss this portion directly with the Doctor.

Do you drive?	Y	N	Do you use tobacco?	Y	N
Do you have difficulty driving?	Y	N	Do you use street drugs?	Y	N
Do you drink alcohol	Y	N	Have you ever been infected with:		
			____ HIV____ Hepatitis ___ Tuberculosis ___		

***Review of Systems*:** Do you currently have or have you ever had any problems in the following areas?

CONSTITUTIONAL	Y	N	RESPIRATORY	Y	N	BONES/JOINTS/MUSCLES	Y	N
Fever, Weight Loss, other			Asthma, Emphysema, COPD, other			Rheumatoid Arthritis, Fibromyalgia, other		
INTEGUMENTARY (skin)	Y	N	CARDIOVASCULAR	Y	N	HEMOTOLOGIC/LYMPHATIC	Y	N
Herpes zoster/shingles, Rosacea, other			Hypertension, Stroke, Heart Disease, other			Leukemia, Anemia, Bleeding, other		
NEUROLOGICAL	Y	N	GASTROINTESTINAL	Y	N	ALLERGIC/IMMUNOLOGIC	Y	N
Headache, Migraines, Seizures, MS, other			Crohns, Ulcer, other			Allergies, Autoimmune Disease, other		
ENDOCRINE	Y	N	GENITOURINARY	Y	N	PSYCHIATRIC	Y	N
Diabetes, Thyroid, other			Kidney, Bladder, other			Anxiety, Depression		

TO BE COMPLETED BY DOCTORS STAFF ONLY

Informed Refusal

I exercise my right to refuse certain diagnostic medical tests that my Doctor has recommended. I have been informed of the reason for the test(s) recommended. I assume the risk for any and all vision loss **(<u>which includes permanent and total blindness</u>)** that may result from the inability of my Doctor to adequately diagnose and treat an eye disease due to my refusal of these diagnostic tests.

Test Refused _____ Signature _____