PATIENT HISTORY

Name _____ Date _____

Age _____ email: _____ Have you previously seen Dr. Brown? *Yes* *No*

Date of last eye exam? _____ by Dr. _____

How did you hear about Dr. Brown? Previous Patient Doctor Referral Family Friend Insurance
TV Radio Newspaper *Name?* _____

Reason for today's exam: Annual Exam Problem Broke/lost glasses

_____

Eye problems: *Do you have?/Are your eyes?*

Red	Itch	Discharge	Glare	Pain	Blurry
Tearing	Burning	Floaters	Cobwebs	Flashes	Dry
Headaches	Halos	Rainbows	Foreign Body	Blind spot	Double Vision
Night blindness	Color Blindness				

Eye drops you are taking:

_____

Do you wear glasses? All the time driving/Night/Movies Reading Never
How old are they? _____ Have you worn glasses in the past? *Yes* *No*
Do you wear contact lenses? *Yes* *No* have you worn contacts in the past? *Yes* *No*

Are you interested in refractive laser surgery? *Yes* *No* *I'd like more information*

Have you been diagnosed with any of the following?

Cataract(s)	Glaucoma	Diabetes	Lazy Eye	Tumor
Retinal Detachment		Retinal Tear/Hole		Macular degeneration

Details _____

Prior Eye Surgeries: Cataract Retina Glaucoma Laser Right Eye Left Eye
Details _____

_____

Immediate family eye history:
Retinals tear/detach. Blindness Glaucoma Cataracts Eye Tumor or Cancer
Other eye problem requiring treatment or causing serious visual loss: _____
Who? _____

GENERAL Medical

- ❑ Weight loss > 10 pounds in 6 months
- ❑ Recurrent or persistent fevers, night sweats
- ❑ Persistent cough, cough up blood
- ❑ Cancer or tumors
- ❑ Serious or unusual infections
- ❑ Diabetes How many years? _____
  - ❑ On Insulin? *Yes* *No*
- ❑ Thyroid, adrenal disease
- ❑ Anemia, bleeding problems, bruise easily
- ❑ Asthma
- ❑ Jaundice
- ❑ AIDS
- ❑ Venereal disease (Syphilis, gonorrhea)
- ❑ Herpes
- ❑ Radiation treatments
- ❑ Chemotherapy

ENT *Have you ever had?*

- ❑ Hearing loss / Ringing in Ears
- ❑ Frequent nose bleeds
- ❑ Dry mouth, excessive thirst
- ❑ Difficulty swallowing
- ❑ Hoarseness or voice loss for over one month
- ❑ Sinus Problems

CVS *Have you ever had?*

- ❑ Chest pain or angina
- ❑ Collagen vascular disease (rheumatoid arthritis, Lupus, Sarcoid)
- ❑ Heart Attack
- ❑ Heart Surgery
- ❑ Heart murmurs, defects

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- ❑ High Blood Pressure How many years?_____
- ❑ Shortness of breath
- ❑ Rheumatic fever
- ❑ Hardening of arteries

GI *Have you ever had?*

- ❑ Ulcers, stomach problems
- ❑ Changes in your eating habits
- ❑ Bloody or black stools
- ❑ Frequent vomiting, nausea
- ❑ Severe diarrhea, constipation
- ❑ Hepatitis

GU *Have you ever had?*

- ❑ Blood in your urine
- ❑ Pass urine more than two times at night
- ❑ Burning with urination, difficulty urinating
- ❑ Kidney disease, bladder problems

EXT *Have you ever had?*

- ❑ Swelling of your ankles or hands
- ❑ Arthritis, joint pain, stiffness
- ❑ Artificial joint
- ❑ Rheumatism
- ❑ Skin diseases, skin cancer
- ❑ Melanoma

NEUROPSYCHIATRIC *Have you ever had?*

- ❑ Dizziness, fainting spells
- ❑ Persistent headaches
- ❑ Migraines
- ❑ Seizures
- ❑ Depression
- ❑ Psychiatric care
- ❑ Stroke
- ❑ Numbness or weakness of your arms or legs

SURGERIES Surgeon Date

_____

_____

_____

Are you or could you be pregnant or nursing? *Yes* *No*

FAMILY HISTORY *Has any blood relative had?*

Diabetes Heart disease Cancer Thyroid

Do any diseases run in your family? _____

SOCIAL HISTORY

Married Single Divorced Number of children_____

Smoke No Packs per day _____how many years?_____

Drink No Socially Frequently Recreational drug use? *Yes* *No*

Occupation_____Type of work? Office Physical/Outside Computer

Type of lighting in workplace: Outside Fluorescent Incandescent Weak Strong

PRESCRIPTION MEDICINES How often

_____

_____

_____

_____

Do your take birth control pills? *Yes* *No* How long? _____

Do you take aspirin regularly? *Yes* *No* How much? _____

ALLERGIES _____

ANNUAL REVIEW

Patient's Signature_____Date_____

Patient's Signature_____Date_____

Patient's Signature_____Date_____

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