

# Patient Eye & Medical History

Pt fills this out -visit 1 or if NP> 3 yrs

V2

Must be filled out even w pt health history

Patient Name \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First M.I. Your Occupation \_\_\_\_\_

Who referred you to us for eye / retinal evaluation today? \_\_\_\_\_ In what city is his/her office? \_\_\_\_\_

Are you giving us a copy of brief health history or medication list today? **Yes No** which \_\_\_\_\_ attach HlthHx \_\_\_\_

**You are here for what main complaints or problems?** List these: Circle **R** and/or **L** for each line:

R L \_\_\_\_\_ for \_\_\_\_\_ days - weeks - months - years Staff-Has pt been here before?  
R L \_\_\_\_\_ for \_\_\_\_\_ days - weeks - months - years Yes - No When? \_\_\_\_\_  
R L \_\_\_\_\_ for \_\_\_\_\_ days - weeks - months - years Chart available? Yes - No

**Have you ever had eye surgery?** Right eye? **Yes No** Left eye? **Yes No**

Note: lasers & LASIK are eye surgeries Circle **R** and/or **L** for each surgery. List these:

R L \_\_\_\_\_ Year \_\_\_\_\_ R L \_\_\_\_\_ Year \_\_\_\_\_  
R L \_\_\_\_\_ Year \_\_\_\_\_ R L \_\_\_\_\_ Year \_\_\_\_\_  
R L \_\_\_\_\_ Year \_\_\_\_\_ R L \_\_\_\_\_ Year \_\_\_\_\_  
R L \_\_\_\_\_ Year \_\_\_\_\_ R L \_\_\_\_\_ Year \_\_\_\_\_

**Past Eye History:** If 'Yes' list days-months-years ago started:

Cataracts **Yes No** R L started \_\_\_\_\_  
Glaucoma **Yes No** R L started \_\_\_\_\_  
Retina tear **Yes No** R L started \_\_\_\_\_  
Retina detachment **Yes No** R L started \_\_\_\_\_  
Macular degeneration **Yes No** R L started \_\_\_\_\_  
Diabetic Retinopathy **Yes No** R L started \_\_\_\_\_  
Bleeding in retina **Yes No** R L started \_\_\_\_\_  
Bleeding in vitreous **Yes No** R L started \_\_\_\_\_  
Uveitis - Iritis **Yes No** R L started \_\_\_\_\_  
Lazy or Crossed Eye **Yes No** R L started \_\_\_\_\_  
Eye Migraine **Yes No** R L started \_\_\_\_\_  
Birth prematurity **Yes No** R L started \_\_\_\_\_  
Myopia-Astigmatism **Yes No** R L started \_\_\_\_\_  
Other \_\_\_\_\_ R L started \_\_\_\_\_

**Eye / Head Injury** **Yes No** When: \_\_\_\_\_

Describe: \_\_\_\_\_

Current Drops - Ointments for **Eyes: Yes No**

\_\_\_\_\_ R L both -times per day \_\_\_\_\_  
\_\_\_\_\_ R L both -times per day \_\_\_\_\_  
\_\_\_\_\_ R L both -times per day \_\_\_\_\_  
\_\_\_\_\_ R L both -times per day \_\_\_\_\_  
\_\_\_\_\_ R L both -times per day \_\_\_\_\_  
\_\_\_\_\_ R L both -times per day \_\_\_\_\_

Current Pills for **Eyes: Yes No** \_\_\_\_\_

Current Medications for **Body: Yes No** \_\_\_\_\_

attach MedList \_\_\_\_

**Do you currently have or being currently treated for any of the following?**

**My family doctor-PCP is** \_\_\_\_\_

Diabetes **Yes No** \_\_\_yrs  
High Blood Pressure **Yes No** \_\_\_yrs  
Heart problem **Yes No** \_\_\_yrs  
Cancer **Yes No** \_\_\_yrs  
Stroke **Yes No** \_\_\_yrs  
Blood disease **Yes No** \_\_\_yrs  
High cholesterol **Yes No** \_\_\_yrs  
Venereal Disease **Yes No** \_\_\_yrs  
HIV positive **Yes No** \_\_\_yrs  
Hypoglycemia **Yes No** \_\_\_yrs  
Migraine headache **Yes No** \_\_\_yrs  
Arthritis **Yes No** \_\_\_yrs  
Other \_\_\_\_\_ **Yes No** \_\_\_yrs  
Other \_\_\_\_\_ **Yes No** \_\_\_yrs  
Other \_\_\_\_\_ **Yes No** \_\_\_yrs

**Allergy** to Eye Drops or ointments? **Yes No** "Answer 'No' unless  
List \_\_\_\_\_ you know that you do"

**Allergy** to Intravenous Fluorescein Fluid? **Yes No**

**Allergy** to Medications? **Yes No**

List \_\_\_\_\_

**General Surgeries (major)** **Yes No** List:

\_\_\_\_\_ When \_\_\_\_\_ When \_\_\_\_\_  
\_\_\_\_\_ When \_\_\_\_\_ When \_\_\_\_\_  
\_\_\_\_\_ When \_\_\_\_\_ When \_\_\_\_\_

Do any of your immediate **blood relatives** have?

Glaucoma? **Yes No** \_\_\_\_\_ Retinal detachment? **Yes No** \_\_\_\_\_

Other eye disease or eye conditions? **Yes No** \_\_\_\_\_

Diabetes - **Yes No** \_\_\_\_\_

Do you drink alcohol, smoke tobacco or take any illegal drugs? **Yes No**

Has a doctor ever told you **not** to have your pupils dilated? **Yes No** → **it's OK to dilate them.**

list \_\_\_\_\_

If 'Yes', Who told you **not** to have your pupils dilated? \_\_\_\_\_ When? \_\_\_\_\_

how often \_\_\_\_\_

Do you read/write English well enough to fill out this form? **Yes No** If 'No' let out staff help you, or return with translator.

Do you understand that **you** must bring a translator if you do not speak English? **Yes No**

pt told \_\_\_\_

Who filled out this form? You, relative, or friend? \_\_\_\_\_

**Relative-Patient Signature** \_\_\_\_\_

**Staff Signature** \_\_\_\_\_ **OCR staff** ✓ form \_\_\_\_\_