PATIENT HISTORY

EAST VIEW EYE CARE, P.C.
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Please Print...

Patient's Name:____________________ **Age:**_____ **Date of Birth:**_________ **Today's Date:**__________

CHIEF COMPLAINT:

List any eye problem(s) or known eye disease(s) you have?________________________________

____

Date of last eye exam: __________________

Name of eye doctor? __________________

Are you planning on getting new glasses?
- ❑ Yes
- ❑ No
- ❑ Only if Rx changes

Do you wear prescription sunglasses?
- ❑ Yes....always!
- ❑ No....never!
- ❑ Sometimes

Contact Lenses?
- ❑ none
- ❑ I currently wear
- ❑ Have worn in past
- ❑ I am interested
- ❑ I am not interested

PERSONAL/SOCIAL HISTORY:

Illegal drug use? **Y N** Are you pregnant or breast feeding? **Y N**

Do you smoke? **Y N** _____ packs/day Alcohol use? **Y N** Are you interested in LASIK surgery? **Y N**

REVIEW OF SYSTEMS:

Do you have:	Yes	No	If Yes, *for how long* and *is it under control*?	Past Family/Social History: Does it run in the family?	*Who?*
Diabetes	❑	❑	________	❑ Y ❑ N	________
High blood pressure	❑	❑	________	❑ Y ❑ N	________
Heart problems	❑	❑	________	❑ Y ❑ N	________
High cholesterol	❑	❑	________	❑ Y ❑ N	________
Cancer	❑	❑	________	❑ Y ❑ N	________
Asthma	❑	❑	________	❑ Y ❑ N	________
Arthritis	❑	❑	________	❑ Y ❑ N	________
Cataracts	❑	❑	________	❑ Y ❑ N	________
Glaucoma	❑	❑	________	❑ Y ❑ N	________
Macular degeneration	❑	❑	________	❑ Y ❑ N	________
Lazy Eye (amblyopia)	❑	❑	________	❑ Y ❑ N	________

Any other problems with:	Yes	No	If Yes, *explain*:
Ears/nose/throat	❑	❑	________
Skin	❑	❑	________
Heart/blood vessels	❑	❑	________
Blood	❑	❑	________
Lungs/breathing	❑	❑	________
Stomach/intestines	❑	❑	________
Muscles/bones	❑	❑	________
Reproductive organs	❑	❑	________
Kidney/bladder	❑	❑	________
Allergies	❑	❑	________
Other problems	❑	❑	________

Family Physician: ____________________ **Date of last physical:** ______________

List all current medications:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________

**** Are you allergic to any ****
**** Medications? ****

1. ____________________
2. ____________________
3. ____________________