❖ ***PATIENT HISTORY*** ❖

EAST VIEW EYE CARE, P.C.
Drs. Emde, Shaw & Combes

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? _____

Were 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** **Weight:**_____lbs. **Height:**____ft.____in.

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 _____
Sleep apnea.....	❑	❑	_____	❑ 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. _____