DATE: **Patient History Record**

Patient's Name:_____ Reason for This Visit: _____

History of This Condition: _____

_____

For patients three years of age or younger:

Birth weight _____ Premature? _____ (If so, how many weeks? _____)

During pregnancy…any ILLNESSES? _____ any MEDICINES? _____ any X-RAYS? _____

During delivery…any complications? _____ During hospital stay…any complications? _____

During baby's life, how has baby's general development been? _____

Please answer the following questions about your (*the patients*) medical status and history:

1. Have you ever been treated for any **MEDICAL CONDITIONS** (e.g., DIABETES, HIGH BLOOD PRESSURE, arthritis, heart, kidney, or thyroid)?
   YES ☐ NO ☐ If YES, please explain: _____
2. Have you ever had any **EYE DISEASE** (e.g., GLAUCOMA, CATARACT, wandering or "lazy" eye, retinal detachment)?
   YES ☐ NO ☐ If YES, please explain: _____
3. Have you ever had any **EYE** or other **SURGERY**?
   YES ☐ NO ☐ If YES, please provide DATE and REASON: _____
4. Have you ever been **HOSPITALIZED**?
   YES ☐ NO ☐ If YES, please provide DATE and REASON: _____
   If YES - Any anesthesia problems? _____ Any healing problems? _____
5. Do you take any **MEDICINES**?
   YES ☐ NO ☐ If YES, please list: _____
   Do you use any **EYE MEDICINES**?
   YES ☐ NO ☐ If YES, please list: _____
6. Do you have any **ALLERGIES** to MEDICINES, food, or other things?
   YES ☐ NO ☐ If YES, please list: _____
7. Do you currently or have you ever:
   Worn glasses? _____ Contacts? _____ Had eye exercises? _____ Had eye patching _____

Review of Systems	**YES**	**NO**	**If YES, Please explain:**
Do you currently have any of the following problems:			
Chronic fever, unexpected weight loss/ gain, fatigue	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pains, diarrhea, vomiting)	☐	☐	
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g., rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	

Family and Social History

Do any medical or eye diseases run your family? (e.g., DIABETES, HIGH BLOOD PRESSURE, cancer, heart disease, bleeding problems, BLINDNESS, CROSSED EYES, LAZY EYE, CATARACT, GLAUCOMA, MACULAR DEGENERATION)

YES ☐ NO ☐ If YES, please list disease and relation: _____

_____

_____

Do you smoke? YES☐ NO☐ Drink alcohol? YES ☐ NO ☐ Use recreational drugs? YES ☐ NO ☐

▲Comments

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