

Patient History

Name _____ Chart No. _____

Drug Allergies _____

Health Problems	Date Updated	Meds	Date Updated	Meds

Previous Surgeries _____

Smoker? Yes No How Much? _____ Alcohol? Yes No How Much? _____

Occupation: _____

Review of Systems – Do you currently have any of the following problems: Yes No

Chronic fever, unexpected weight loss/gain fatigue _____

Ear/nose/throat problems (e.g. hearing loss, sinus problem, 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 pain, 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 History of Medical Problems _____

Medical Physician: _____ Referred By: _____

Past Ocular History (Injuries, Surgeries, Lasers)
