THE Vision Care CENTER

PATIENT HISTORY

Chart # _____

Name: _____ Date: _____

DOB: _____ Age: _____ Sex: ❑ M ❑ F Occupation: _____

Phone (Home): _____ Phone (Work): _____

Referral: _____ Primary Physician: _____

Are you interested in knowing if you are a candidate for Laser Vision Correction such as LASIK? ❑ Yes ❑ No

Past History

Allergies _____ Latex Sensitive? ❑ Yes ❑ No

Medications: (Please list eyedrops first) _____

_____

_____

Previous Eye History

Glaucoma: ❑ Yes ❑ No _____

Macular Degeneration: ❑ Yes ❑ No _____

Diabetic Retinopathy: ❑ Yes ❑ No _____

Retinal Detachment: ❑ Yes ❑ No _____

Cataract: ❑ Yes ❑ No _____

Eye Injuries: ❑ Yes ❑ No _____

Family Eye History

❑ Yes ❑ No _____

❑ Yes ❑ No _____

❑ Yes ❑ No _____

❑ Yes ❑ No _____

❑ Yes ❑ No _____

Previous Medical History (please list duration or date of onset, if known)

Diabetes: ❑ Yes ❑ No _____

Hypertension: ❑ Yes ❑ No _____

Heart Disease: ❑ Yes ❑ No _____

Asthma or Pulmonary Disease: ❑ Yes ❑ No _____

Thyroid Disease: ❑ Yes ❑ No _____

Arthritis: ❑ Yes ❑ No _____

Other: _____

_____

Previous surgery or anesthesia? ❑ Yes ❑ No

If yes, please provide date and reason _____

_____

Previous Hospitalization? ❑ Yes ❑ No

If yes, please provide date and reason _____

_____

Do any medical diseases run in your family? (diabetes, high blood pressure, cancer, heart disease) ❑ Yes ❑ No

If Yes, please explain:

_____

Social History

Do you smoke? ❑ Yes ❑ No If Yes, how much? _____

Do you drink alcohol? ❑ Yes ❑ No If Yes, how much? _____

Hobbies/Interests: _____

please continue on back...

Review of Systems (Vision)

Any difficulty pursuing Hobbies/Interests due to vision? ❑ Yes ❑ No If Yes, Please explain: _____

_____

Do you drive? ❑ Yes ❑ No If Yes, do you have visual difficulty when driving? ❑ Yes ❑ No

Trouble reading street signs? ❑ Yes ❑ No Trouble with glare or bright lights ❑ Yes ❑ No

Trouble with night vision? ❑ Yes ❑ No Other: _____

Do you have difficulty seeing to read? ❑ Yes ❑ No If Yes, please explain: _____

_____

Review of Systems (Systemic)

Do you currently have any of the following problems?:	**Yes**	**No**
Allergy (hay fever, dust, dander, pollen, food, preservatives)	❑	❑
If Yes, please explain: _____		
Heart problems (chest pain, irregular heart beat)	❑	❑
If Yes, please explain: _____		
Constitutional (chronic fever, unexpected weight loss/gain, fatigue)	❑	❑
If Yes, please explain: _____		
Endocrine (Diabetes, Thyroid)	❑	❑
If Yes, please explain: _____		
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting	❑	❑
If Yes, please explain: _____		
Genitourinary problems (pain or discomfort, blood in urine)	❑	❑
If Yes, please explain: _____		
Ear/nose/throat problems (hearing loss, sinus problems, sore throat)	❑	❑
If Yes, please explain: _____		
Hematologic/Lymphatic (bruising, bleeding)	❑	❑
If Yes, please explain: _____		
Immunologic (frequent infections, HIV)	❑	❑
If Yes, please explain: _____		
Integumentary (skin) problems (rashes, excessive dryness)	❑	❑
If Yes, please explain: _____		
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	❑	❑
If Yes, please explain: _____		
Neurologic problems (numbness, weakness, headaches, paralysis	❑	❑
If Yes, please explain: _____		
Psychiatric problems (depression, anxiety)	❑	❑
If Yes, please explain: _____		
Respiratory problems (shortness of breath, wheezing, coughing)	❑	❑
If Yes, please explain: _____		

Date _____ Patient Siganature _____

Date _____ Physician Signature _____