CEI
CINCINNATI EYE INSTITUTE

ROS

TODAY'S DATE: ______________

MW # ______________________

PATIENT HISTORY FORM

Patient Name: ________________________ **SS#:** ________________ **Date of Birth:** __________

Primary Care Physician: ________________________ **Optometrist:** ________________________

Cardiologist: ____________________ **Medication Allergies & Reactions:** ______________________

Pharmacy: ______________________ **Pharmacy Phone #** (_______)____________________________

History of Latex Allergy? ☐ YES ☐ NO **Height**:____________ **Weight**: ____________

Have you or any family members had an anesthesia reaction? ☐ YES ☐ NO

REVIEW OF SYSTEMS - Do you currently have any of the following problems?

System	Yes/No	Date Diagnosed	Condition/Current Treatment/Surgery
Eye disease, eye injury, eye surgery	☐ Yes ☐ No		
Constitutional (fever, weight loss, other)	☐ Yes ☐ No		
Ears (reduced hearing or hearing loss)	☐ Yes ☐ No		
Nose/Mouth/Throat (sinus problems, sore throat)	☐ Yes ☐ No		
Cardiovascular (heart,vascular) hypertension	☐ Yes ☐ No		
Pacemaker/Defibrillator	☐ Yes ☐ No		
Respiratory (breathing problems, lungs, cough)	☐ Yes ☐ No		
Gastrointestinal (heartburn, diarrhea, vomiting, GERD, acid reflux)	☐ Yes ☐ No		
Neurological (numbness, weakness, stroke, headaches, paralysis,)	☐ Yes ☐ No		
Females – Pregnant? / Nursing?	☐ Yes ☐ No		
Genitourinary (male or female organ problems, urinary problems, kidneys)	☐ Yes ☐ No		
Dialysis	☐ Yes ☐ No		
Dermatologic (skin rashes, excessive dryness)	☐ Yes ☐ No		
Musculoskeletal (muscle or joint problems)	☐ Yes ☐ No		
Rheumatoid Arthritis	☐ Yes ☐ No		
Diabetes/Thyroid	☐ Yes ☐ No		
Allergic/Immunologic	☐ Yes ☐ No		
Psychiatric (depression)	☐ Yes ☐ No		
Hematologic (bleeding tendency, anemia)	☐ Yes ☐ No		
Cancer (Type):	☐ Yes ☐ No		

FAMILY HISTORY:

☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Cataracts
☐ Yes ☐ No Retinal disease
☐ Yes ☐ No Other eye problems ______________________________

SOCIAL HISTORY:

Marital Status: ☐ Married ☐ Single ☐ Widowed
Currently Employed: ☐ Yes ☐ No
If yes, occupation: ______________________
Use of Tobacco/Alcohol/Drugs: ☐ Yes ☐ No
Comments: ______________________

Please list all individuals you authorize to receive information about your care:

Individual	Relationship	Phone

***Please turn over and complete other side**

Patient Name: ____ **MW#:** ____________________ ROS

Current Prescribed/Over-The-Counter Medications:

Name of Prescription/Medication	Taken for what condition	Dosage	Frequency

Have you ever taken any of the following medications? If Yes, please check box

☐ **Cardura** ☐ **Finasteride** ☐ **Hytrin** ☐ **Uroxatral** ☐ **Flomax** ☐ **Proscar**

History of any major illnesses, injuries or surgeries:

Procedure	Reason	When?

VISUAL FUNCTION QUESTIONS

Please check Yes or No if you are experiencing any difficulty with the following:

	Yes	No	Comments
Reading small print			
Reading newspaper or book			
Recognizing people when close			
Seeing steps, stairs, or curbs			
Difficulty driving on bright sunny days			
Difficulty driving at night			
Reading traffic signs, street signs			
Doing fine handiwork			
Writing checks, completing forms			
Playing games (i.e. bingo, cards)			
Taking part in sports (i.e. golf, tennis)			
Cooking/Hobbies			
Watching TV			
Bothered by glare/halos			
If yes, please describe			
Are you satisfied with your current vision?			

Patient's Signature:____ Date:____________________

Physician's Signature:____ Date:____________________

Reviewed/Updated Date: ____________ Interval Changes ☐ Yes ☐ No MD Signature: ________________________