Today's Date: ________________

CEI
CINCINNATI EYE INSTITUTE

ROS

Account # ________________

PATIENT HISTORY FORM

Patient Name: ________________ **SS#:** ________________ **Date of Birth:** ____________

Primary Care Physician: ________________ **Optometrist:** ________________

Cardiologist: ________________ **Endocrinologist:** ________________

Pharmacy: ________________ **Pharmacy Phone #** (_______)________________

Pharmacy Address: ________________

History of Latex Allergy? ☐ YES ☐ NO **Have you or any family members had an anesthesia reaction?** ☐ YES ☐ NO

Medication Allergies & Reactions: ________________ **Height:**________ **Weight:** ________

REVIEW OF SYSTEMS - Do you currently have or have you recently had any of the following?

System		Yes/No	System		Yes/No
Constitutional:	Fever	☐ Yes ☐ No	**Metabolic/**	Intolerant to: ☐ Cold ☐ Heat	☐ Yes ☐ No
	Weight: ☐ Loss ☐ Gain	☐ Yes ☐ No	**Endocrine:**	Excessive Thirst	☐ Yes ☐ No
Eyes:	Double Vision	☐ Yes ☐ No		Urinating more than usual	☐ Yes ☐ No
	Sensitivity to Light	☐ Yes ☐ No	**Neurological:**	Weakness	☐ Yes ☐ No
	Pain	☐ Yes ☐ No		Headache	☐ Yes ☐ No
	Floaters	☐ Yes ☐ No		Numbness of Extremities	☐ Yes ☐ No
ENT:	Hearing Loss	☐ Yes ☐ No	**Psychiatric:**	Depressed Mood	☐ Yes ☐ No
	Sinus Problems	☐ Yes ☐ No	**Integumentary/Skin:**		
	Sore Throat	☐ Yes ☐ No		Dry Skin	☐ Yes ☐ No
Respiratory:	Asthma	☐ Yes ☐ No		Rash	☐ Yes ☐ No
	Cough	☐ Yes ☐ No	**Musculoskeletal:**	Arthritis	☐ Yes ☐ No
Cardiovascular:	Chest Pressure or Discomfort	☐ Yes ☐ No		Joint Swelling	☐ Yes ☐ No
	Irregular Heartbeat/Palpitations	☐ Yes ☐ No	**Hematologic/Lymphatic:**		
Gastrointestinal:	Diarrhea	☐ Yes ☐ No		Easily: ☐ Bleeds ☐ Bruises	☐ Yes ☐ No
	Heartburn	☐ Yes ☐ No		Swollen Lymph Nodes	☐ Yes ☐ No
	Vomiting	☐ Yes ☐ No	**Allergic/Immunologic:**		
Genitourinary:	Kidney Stones	☐ Yes ☐ No		☐ Environmental ☐ Food ☐ Seasonal	☐ Yes ☐ No

Please list all Prescribed and Over-The-Counter Medications, including vitamins and supplements, you are currently taking:

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** ☐ **Jalyn**

Ocular History

Do you currently have, or have you ever had:	Yes/No	Eye	Diagnosis	Current Treatment/ Previous Surgery	When?
Eye disease	☐ Yes ☐ No				
Eye Injury	☐ Yes ☐ No				
Eye Surgery	☐ Yes ☐ No				

ROS

Patient Name: ______________________________ Acct#: ________________

Medical History

Do you now, or have you ever had:	Yes/No	Current Treatment/ Previous Surgery	When?
Diabetes (Type)	☐ Yes ☐ No		
Heart Disease	☐ Yes ☐ No		
Pacemaker / Defibrillator ☐ Yes ☐ No			
High Blood Pressure	☐ Yes ☐ No		
High Cholesterol	☐ Yes ☐ No		
Kidney Failure **(Dialysis** ☐ Yes ☐ No **)**	☐ Yes ☐ No		
Liver Disease	☐ Yes ☐ No		
Stroke	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No		
Thyroid Disease:	☐ Yes ☐ No		
☐ **Overactive** ☐ **Underactive**			
Cancer or Tumor (Type)	☐ Yes ☐ No		
Females: ☐ **Pregnant** ☐ **Nursing**	☐ Yes ☐ No		
Other Medical Problems or Surgeries:	☐ Yes ☐ No		

FAMILY HISTORY: Relationship

☐ Yes ☐ No High blood pressure ____________
☐ Yes ☐ No Diabetes ____________
☐ Yes ☐ No Cancer ____________
☐ Yes ☐ No Glaucoma ____________
☐ Yes ☐ No Cataracts ____________
☐ Yes ☐ No Retinal disease ____________
☐ Yes ☐ No Other eye/medical problems (Please Specify)________________________________

SOCIAL HISTORY:

Use of Tobacco: ☐ Current ☐ Former ☐ Never
Amount: ____________________
Alcohol: ☐ Yes ☐ No
Amount: ____________________
Drugs: ☐ Yes ☐ No

VISUAL FUNCTION QUESTIONS

Please check Yes or No if you are experiencing any difficulty with the following while wearing your glasses or contacts:

	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?			

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

Individual	Relationship	Phone

Patient's Signature:______________________________ Date:________________

Physician's Signature:______________________________ Date:________________

Reviewed/Updated Date: __________ Interval Changes ☐ Yes ☐ No MD Signature: ________________