

TODAY'S DATE: _____

MW # _____

PATIENT HISTORY FORM

Patient Name: _____ SS#: _____ Date of Birth: _____

Home Phone: _____

Primary Care Physician: _____ Optometrist: _____

Cardiologist: _____ Medication Allergies & Reactions: _____

Pharmacy: _____ Pharmacy Phone # (_____) _____

History of Latex Allergy? YES NO Height: _____ Weight: _____

Race: _____ Language: _____ Ethnicity: _____

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

