# MID OHIO EYE

*The difference is clear!*

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## PATIENT HISTORY FORM

Today's Date: ____________________ Account #: ________________

Patient Name: ______________________________________________ Date of Birth: ___/ ___/ ____

Pharmacy: ______________________ Pharmacy Phone: (____) ____ - ______ Location: ______________________

History of Latex Allergy? [ ] Yes [ ] No Have you or any family members had an anesthesia reaction? [ ] Yes [ ] No

Medication Allergies and Reactions: ______________________________________ Occupation: ___________________

Age: _______________ Height: ______ ft _________ in Weight: __________________ lbs

## MEDICAL HISTORY (Check All That Apply)

| | | |
|---|---|---|
| [ ] Allergies | [ ] Gout | [ ] Osteoporosis |
| [ ] Alzheimer's | [ ] Headaches / Migraines | [ ] Parkinson's |
| [ ] Anemia | [ ] Hearing Loss | [ ] Melanoma |
| [ ] Arthritis Type ______ | [ ] Heart Attack | [ ] Rosacea |
| [ ] Asthma | [ ] Heart Disease | [ ] Rheumatoid Arthritis |
| [ ] Atrial Fibrillation | [ ] High Blood Pressure | [ ] Schizophrenia |
| [ ] Cancer Type ______ | [ ] High Cholesterol | [ ] Sleep Apnea |
| [ ] COPD | [ ] HIV | [ ] Stroke |
| [ ] Dementia | [ ] IBS | [ ] Thyroid Disorder |
| [ ] Depression | [ ] Liver disease | [ ] Tuberculosis (TB) |
| [ ] Diabetes Type [ ] 1 or [ ] 2 | [ ] Lupus | [ ] **OTHER MEDICAL CONDITIONS:** |
| [ ] Enlarged Prostate | [ ] Mitral Valve Prolapse | |
| [ ] Epilepsy | [ ] Multiple Sclerosis | [ ] **LIST SURGERIES AND TRAUMA:** |
| [ ] Fibromyalgia | [ ] MRDD | |
| [ ] GERD | [ ] Obesity | |

## FAMILY/SOCIAL HISTORY

| | | Relationship | | | Relationship |
|---|---|---|---|---|---|
| [ ] Yes [ ] No | High blood pressure | ____________ | [ ] Yes [ ] No | Cataracts | ____________ |
| [ ] Yes [ ] No | Diabetes | ____________ | [ ] Yes [ ] No | Retinal disease | ____________ |
| [ ] Yes [ ] No | Cancer | ____________ | [ ] Yes [ ] No | Macular degeneration | ____________ |
| [ ] Yes [ ] No | Glaucoma | ____________ | [ ] Yes [ ] No | Keratoconus | ____________ |

Tobacco Use: [ ] Never [ ] Former [ ] Current Amount: _____________ Recreational Drugs: [ ] Yes [ ] No

Alcohol: [ ] Yes [ ] No Amount: ___________________________

## FUNCTIONAL STATUS

Cognitive Status: [ ] No impairment [ ] Impaired

ADA: [ ] Performs all daily functions without assistance [ ] Requires assistance

Disability: [ ] No disability [ ] Disability affecting daily living

| Name of Medication | Strength/Dose | How often taken / Route | Reason for taking |
|---|---|---|---|
| **Please list Prescribed and Over-The-Counter medications you are currently taking, including vitamins and supplements:** | | | |
| Example: Celebrex | Example: (1) 100mg | Example: Twice a day, by mouth | Example: Arthritis |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever taken any of the following medications? If YES, please check each that applies

[ ] Uroxatral [ ] Flomax [ ] Cardura [ ] Finasteride [ ] Hytrin [ ] Proscar [ ] Jalyn

Patient Name: ______________________________________________________________ Date of Birth: ___/ ___/ ____

## OCULAR HISTORY

| Past Ocular History: *(Check Which Eye)* | | | | | | |
|---|---|---|---|---|---|---|
| | [ ] Cataracts | [ ] R | [ ] L | [ ] Glaucoma, you or family | [ ] R | [ ] L |
| | [ ] Double Vision | [ ] R | [ ] L | [ ] Retinal Tear / Detachment | [ ] R | [ ] L |
| | [ ] Strabismus | [ ] R | [ ] L | [ ] Herpes Simplex / Zoster | [ ] R | [ ] L |
| [ ] No Past Eye History | [ ] Dry Eyes | [ ] R | [ ] L | [ ] Amblyopia / Lazy Eye | [ ] R | [ ] L |
| | [ ] Sjogrens | [ ] R | [ ] L | [ ] Recurrent Corneal Erosion | [ ] R | [ ] L |
| | [ ] Corneal Abrasion | [ ] R | [ ] L | [ ] Trauma / Foreign Body / Scar | [ ] R | [ ] L |
| | [ ] Karatoconus, you or family | [ ] R | [ ] L | [ ] Corneal Disease | [ ] R | [ ] L |
| | [ ] Macular Degeneration | [ ] R | [ ] L | [ ] Floaters | [ ] R | [ ] L |

| Past Ocular Surgery: *(Check Which Eye)* | | | | | | |
|---|---|---|---|---|---|---|
| | [ ] PRK | [ ] R | [ ] L | [ ] Glaucoma Surgery | [ ] R | [ ] L |
| | [ ] RK / AK | [ ] R | [ ] L | [ ] Retinal Surgery | [ ] R | [ ] L |
| | [ ] LASIK | [ ] R | [ ] L | [ ] Cataract Surgery | [ ] R | [ ] L |
| [ ] No Past Eye Surgery | [ ] Muscle Surgery | [ ] R | [ ] L | [ ] Other: ________________________ | [ ] R | [ ] L |
| | [ ] Corneal Transplant | [ ] R | [ ] L | ________________________________ | | |

Do you wear glasses regularly? [ ] Yes [ ] No

If yes, how old are your glasses? _______ Do you want to be checked for new glasses today? [ ] Yes [ ] No

Contact Lens History:

- [ ] No contact lenses
- [ ] Soft Daily Wear
- [ ] Soft Overnight Wear
- [ ] Soft Toric
- [ ] RGP Years Worn: ____
- [ ] PMMA Years Worn: ____
- [ ] Monovision Lenses
- [ ] Bifocal Lenses

If you wear contact lenses, when were they last worn? ______________________

If you have ever had difficulty with Contact Lens wear, please explain:
___________________________________
___________________________________
___________________________________

## REVIEW OF SYSTEMS - Please check all that *currently* apply

| | | | | |
|---|---|---|---|---|
| **Constitutional** | **EMNT** | [ ] Jaundice | [ ] Insulin pump | [ ] Shortness of breath |
| [ ] Chronic fatigue syndrome | [ ] Dry mouth/throat | [ ] Nausea | [ ] Thyroid disorder | [ ] Wheezing |
| [ ] Fever | [ ] Dizziness | [ ] Vomiting | **Neurological** | **Psychiatric** |
| [ ] Night sweats | [ ] Ear pain/ringing | **Genitourinary** | [ ] Fainting | [ ] Anxiety |
| [ ] Weight loss | [ ] Sinus problems | [ ] Cystitis | [ ] Alzheimer's | [ ] Depression |
| [ ] Weight gain | [ ] Hearing loss | [ ] Enlarged prostate | [ ] Confusion | [ ] Bipolar |
| **Integumentary (Skin)** | **Cardiovascular** | [ ] Frequent urination | [ ] MS | [ ] Panic attacks |
| [ ] Breast cancer | [ ] Chest pain | [ ] Difficulty urinating | [ ] Memory loss | [ ] Paranoia |
| [ ] Skin cancer | [ ] CHF | [ ] Kidney disease | [ ] Numbness/tingling | [ ] Schizophrenia |
| [ ] Dryness | [ ] Fast or irregular | [ ] Prostate cancer | [ ] Paralysis | **Allergy/Immunologic** |
| [ ] Jaundice | heart beat | **Musculoskeletal** | [ ] Stroke | [ ] Seasonal allergies |
| [ ] Rosacea | [ ] Heart disease | [ ] Arthritis | [ ] Learning disability | [ ] Hay fever |
| [ ] Excema | [ ] Heart attack | [ ] Back pain | [ ] Headaches | [ ] Persistent infection |
| [ ] Psoriasis | [ ] Coronary heart disease | [ ] Gout | [ ] Parkinson's | **MRSA** |
| **Hematological/Lymphatic** | **Gastrointestinal** | [ ] Osteoporosis | [ ] Seizures | [ ] Carrier |
| [ ] Anemia | [ ] Colitis | [ ] Joint pain | **Respiratory** | [ ] Current Issue |
| [ ] Easy bruising | [ ] Constipation | [ ] Muscle weakness | [ ] Allergies | **Hepatitis** |
| [ ] Prolonged bleeding | [ ] Diverticulitis | [ ] Lupus | [ ] Asthma | [ ] A [ ] B [ ] C |
| [ ] AIDs | [ ] Diarrhea | **Endocrine** | [ ] Cough | |
| [ ] HIV | [ ] GERD | [ ] Cold intolerance | [ ] COPD | **Females:** |
| [ ] Sarcoidosis | [ ] IBS | [ ] Heat intolerance | [ ] Lung cancer | [ ] Pregnant |
| [ ] Leukemia | [ ] Heartburn | [ ] Excessive thirst | [ ] Sleep apnea | [ ] Nursing |
| | [ ] Crohn's disease | [ ] Diabetes | | |

## VISUAL FUNCTION QUESTIONS

Please check Right (R) or Left (L) if you are having any difficulty with the following while wearing your glasses/contacts (if applicable)

| | | | | | |
|---|---|---|---|---|---|
| Reading small print | [ ] R | [ ] L | Writing checks, completing forms | [ ] R | [ ] L |
| Reading newspaper or book | [ ] R | [ ] L | Playing games (i.e. Bingo, cards) | [ ] R | [ ] L |
| Recognizing people when close | [ ] R | [ ] L | Taking part in sports (i.e. golf, tennis) | [ ] R | [ ] L |
| Seeing steps, stairs, or curbs | [ ] R | [ ] L | Cooking / Hobbies | [ ] R | [ ] L |
| Difficulty driving on bright sunny days | [ ] R | [ ] L | Watching TV | [ ] R | [ ] L |
| Difficulty driving at night | [ ] R | [ ] L | Bothered by glare / halos | [ ] R | [ ] L |
| Reading traffic signs, street signs | [ ] R | [ ] L | If yes, please describe: | | |
| Doing fine handiwork | [ ] R | [ ] L | Are you satisfied with your current vision? | [ ] R | [ ] L |

Patient Signature: ______________________________________________ Date: _________________