Mid Ohio Eye

Physicians & Surgeons

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	[ ] Dry Eyes	[ ] R [ ] L	[ ] Amblyopia / Lazy Eye	[ ] R [ ] L
Eye History	[ ] 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	[ ] Muscle Surgery	[ ] R [ ] L	[ ] Other: _____	[ ] R [ ] L
Surgery	[ ] 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 Toric	If you have ever had difficulty with Contact Lens wear, please explain:
	[ ] Soft Daily Wear	[ ] RGP Years Worn: ____	_____
If you wear contact lenses, when were they last worn?	[ ] Soft Overnight Wear	[ ] PMMA Years Worn: ____	_____
_____		[ ] Monovision Lenses	_____
		[ ] Bifocal Lenses	

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: _____