REEVE-WOODS EYE CENTER PATIENT HISTORY

Name: _____ Birth Date: _____ Sex: ☐M ☐F Chart No: _____

Date Reviewed: _____

MEDICATIONS:

_____
_____
_____
_____
_____
_____

DRUG ALLERGIES/Intolerances:

_____
_____
_____
_____
_____
_____

(Are you taking: ASPIRIN MOTRIN or any other BLOODTHINNERS?)

EYE HISTORY	Yes	No	Explain
Amblyopia/Lazy Eye	☐	☐	_____
Cataract	☐	☐	_____
Diabetic Eye Disease	☐	☐	_____
Dry Eyes/Allergies	☐	☐	_____
Glaucoma	☐	☐	_____
Iritis	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Eye Injuries	☐	☐	_____

Other: _____

_____

EYE SURGERIES: _____

_____

_____

MEDICAL Hx/R.O.S.	Yes	No	Explain
Arthritis/Edema	☐	☐	_____
Bleeding Disorder/Anemia	☐	☐	_____
Cancer	☐	☐	_____
Diabetes: Since _____	☐	☐	_____
--(Insulin?_____)			
Ears/Nose/Mouth/Throat	☐	☐	_____
Genital/Urinary	☐	☐	_____
Heart	☐	☐	_____
High Blood Pressure	☐	☐	_____
Immunologic Problem	☐	☐	_____
Lung/Asthma/Emphysema	☐	☐	_____
Psychiatric	☐	☐	_____
Skin	☐	☐	_____
Stroke/Seizure(Neuro)	☐	☐	_____
Thyroid/Endocrine	☐	☐	_____
Ulcer/Kidney/Intestine	☐	☐	_____
Weight Loss/Gain(recently)	☐	☐	_____

Other: _____

_____

SURGERIES: _____

_____

FAMILY Hx	Father	Mother	Sibling	Other
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Retinal Disease	☐	☐	☐	☐

Other: _____

_____

SPECIAL NEEDS

☐ Wheelchair ☐ Legally Blind
☐ Hearing Aid ☐ Interpreter

Other: _____

_____

SOCIAL HISTORY

Marital Status? M S D W
Live Alone? Y N Nursing Home
Tobacco Use? Y N
Alcohol Use? Y N
Occupation: _____ Retired
Hobbies: _____

Family Medical Doctor: _____
Eye Care Specialist: _____ MD/OD
Pharmacy: _____

Use back of this form if additional space is needed