PRAIRIE

Eye Center

PATIENT HISTORY FORM **Date:** / /

PATIENTS NAME:	ALLERGIES:
DOB:	
EYE DOCTOR / OPTOMETRIST:	EYE DROPS / EYE VITAMINS:
REFERRED BY:	
PRIMARY CARE PHYSICIAN:	***PHARMACY/LOCATION:**
PAST EYE SURGERY: **(TYPE/DATE/SURGEON)**	
RIGHT Cataract Surg: Yes No LEFt Cataract Surg: Yes No	CURRENT MEDICATIONS:
	LIST ATTACHED Yes or No (circle one)
OTHER SURGERY HISTORY: (TYPE/DATE)	

MEDICAL HISTORY

Have you had MRSA or an antibotic resistant infection in the past? YES (circle one) NO

Have you **ever** been or **currently** taking **Flomax**? (For prostate or urinary problems). **Yes No**

DO YOU HAVE OR HAVE YOU HAD?	YES	Diagnosed	NO
DIABETES			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
STROKE			
HEART ATTACK/FAILURE			
STOMACH ULCERS			
CANCER/TUMOR			
SICKLE CELL			
EMPHYSEMA			
ASTHMA/COPD			
HEPATITIS			
THYROID DISEASE			
RHEUMATOID ARTHRITIS			
LUPUS			
MIGRAINES			
LAZY EYE			
EYE INFECTION			
EYE INJURY			
BLINDNESS			
GLAUCOMA			
DEPRESSION/ANXIETY			
DO YOU WEAR GLASSES?			
DO YOU WEAR CONTACTS			
OTHER CONDITIONS			

FAMILY HISTORY	YES	NO
GLAUCOMA		
MACULAR DEGENERATION		
RETINAL DETACHMENT		
CATARACTS		
LAZY EYE		
DIABETES		
HIGH BLOOD PRESSURE		

SOCIAL HISTORY	YES	NO
DO YOU SMOKE?		
DO YOU CONSUME ALCOHOL?		
IF YES HOW MUCH?_____		

HISTORY TAKEN BY: TECH:

MD/OD SIGNATURE:

COMMENTS

YR___ Dr___ MC___ DM DICT___ YR___ DR___ MC___ DM DICT___

HEIGHT_____ WEIGHT_____ **PQRI** **DATE** **CODE**