HIGHLAND CLINIC

OPHTHALMOLOGY
PATIENT HISTORY FORM
FAX TO 4451

DATE: _____

PCP/REFERRING MD
_____

Name:_____DOB:_____Age:_____

Reason for Visit:_____

Past Medical History:
Do you have?

- ☐ None
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Thyroid Disease
- ☐ Other_____
- ☐ Cancer
- ☐ Depression
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Gout
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure
- ☐ GERD/Reflux
- ☐ COPD/ Emphysema
- ☐ Allergy/Hayfever
- ☐ High Cholesterol

Past Eye Surgical History:
Have you had?

- ☐ Cataract Surgery
- ☐ Glaucoma Surgery
- ☐ Retina Surgery
- ☐ Other_____
- ☐ None

Eye Diseases list any you have?

_____
_____

Family History of Eye Diseases and relationship
(father/mother/sister/brother/etc)

- ☐ Glaucoma_____
- ☐ Cataracts_____
- ☐ Retinal _____
- ☐ Blindness_____
- ☐ None
- ☐ Other_____

Social History:

- ☐ Alcohol Use Yes No
- ☐ Drug Use Yes No

Tobacco Use ☐ current ☐ former ☐ never
Type_____ _____amt/day

Allergies: ☐NONE or list each allergy_____

Medications: *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)* ☐ None

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Review of Systems: ***Do you have?***

- ☐ Fatigue
- ☐ Chills
- ☐ Fever
- ☐ Confusion
- ☐ Fainting
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Food Allergies
- ☐ Difficulty walking
- ☐ Skin Rash
- ☐ Skin Lesion
- ☐ Chronic Headache
- ☐ Constipation
- ☐ Reflux
- ☐ Blood in stool
- ☐ Hair Loss
- ☐ Hives
- ☐ Tremors
- ☐ Nausea/Vomiting
- ☐ Seizures
- ☐ Diarrhea
- ☐ Depression
- ☐ Bruising
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Weakness in arms or legs
- ☐ Dry Mouth
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Asthma
- ☐ Blood in Urine
- ☐ Coughing up Blood
- ☐ Swollen/painful joints
- ☐ Hayfever
- ☐ Falls
- ☐ hoarseness