

## Patient Symptom and History Form

| <b>Patient's Full Name:</b>  | <b>Patient's Birth Date:</b> | <b>Today's Date:</b> |  |
|--|------------------------------|----------------------|--|
| <b>SECTION 1. Current Symptoms:</b> Please read the following list of symptoms and mark all of those that you are experiencing <i>today</i> or have experienced since <b>your last visit</b> . If you mark any item with a <b>“YES,”</b> please provide any additional information you have including <i>how long</i> you have been experiencing this symptom. |                              |                      |  |
| Symptoms   | YES                          | NO                   | If “Yes,” please describe & include any additional information |
| Blurred vision   |                              |                      |  |
| Fluctuating vision   |                              |                      |  |
| Distorted vision   |                              |                      |  |
| Complete or sudden loss of vision  |                              |                      |  |
| Halos around bright objects  |                              |                      |  |
| Loss of side or peripheral vision  |                              |                      |  |
| Double vision  |                              |                      |  |
| Increased number, stationary or shower of floaters or spots  |                              |                      |  |
| Veil, shadow or spider web effect  |                              |                      |  |
| Dryness  |                              |                      |  |
| Redness  |                              |                      |  |
| Discharge of mucous or pus   |                              |                      |  |
| Excess tearing or watering   |                              |                      |  |
| Sandy or gritty sensation  |                              |                      |  |
| Itchy sensation  |                              |                      |  |
| Burning sensation  |                              |                      |  |
| Foreign body sensation   |                              |                      |  |
| Sensitivity to light   |                              |                      |  |
| Eye pain or soreness   |                              |                      |  |
| Headaches  |                              |                      |  |
| Tired eyes   |                              |                      |  |
| Crossed or lazy eyes   |                              |                      |  |
| Drooping eyelid  |                              |                      |  |
| Any other eye-related symptoms   |                              |                      |  |

**SECTION 2. Medications and Allergies:**

List any medications (oral, drops, injections, etc.) that you are currently taking including both prescription and over-the-counter medications:

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Do you have any allergies to any medications? **YES** **NO** If yes, please list:

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Do you have allergies to any other substances such as Latex? **YES** **NO** If yes, please list:

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| <b>SECTION 3. Vision History:</b>                                    | <b>YES</b> | <b>NO</b> | <b>If “Yes,” please describe &amp; include any additional information</b> |
|--|------------|-----------|---|
| Do you wear glasses?   |            |           | If “Yes,” how long with current prescription?                             |
| Do you wear contact lenses?  |            |           | If “Yes,” how long?   |
| Have you ever tried to wear contact lenses?                          |            |           |   |
| Have you ever had vision correction surgery (LASIK, RK, ALK, PRK)?   |            |           | If “Yes,” please describe.  |
| Do you drive?  |            |           |   |
| Do you have any visual difficulty when driving?                      |            |           |   |
| Do you have any problems with night vision?                          |            |           |   |
| Do you have vision problems while reading or watching TV or movies?  |            |           |   |
| Do you have any other life style limitations due to vision problems? |            |           |   |

**SECTION 4. Personal Medical History:** Please read the following list of body systems and mark an item if you have had a *significant illness, disease, injury or surgery* involving that body system. If you mark an item as “**YES,**” please provide any additional information you have including the *specific disease, illness or type of surgery and when it occurred.*

| <b>System</b>   | <b>YES</b> | <b>NO</b> | <b>Please describe illnesses/surgeries/injuries/problems</b> |
|---|------------|-----------|--|
| Eyes (cataract, glaucoma, retinal problems, injuries, etc.) |            |           |  |
| Cardiovascular (high blood pressure, heart attack)          |            |           |  |
| Respiratory (lungs, asthma, emphysema)                      |            |           |  |
| Gastrointestinal (stomach, ulcers, intestinal disease)      |            |           |  |
| Urinary/Reproductive  |            |           |  |
| Muscles/Bones/Joints (arthritis, etc.)                      |            |           |  |
| Skin  |            |           |  |
| Neurological (multiple sclerosis, stroke, etc.)             |            |           |  |
| Endocrine (diabetes, hypothyroid, etc.)                     |            |           |  |
| Ears/Nose/Throat  |            |           |  |
| Blood and Lymph (high cholesterol, anemia, etc.)            |            |           |  |
| Immunologic (Lupus, HIV)                                    |            |           |  |
| Psychiatric (anxiety, depression, insomnia)                 |            |           |  |

**SECTION 5. Family Medical History:** Please read the following list of conditions and mark all of those of which you have a *family history*. If you mark any as “**YES,**” please indicate which *blood relative* has experienced this condition.

| <b>Condition</b>                     | <b>YES</b> | <b>NO</b> | <b>Relationship to Patient (Mother/Father/Sibling/Grandparent, etc.)</b> |
|--------------------------------------|------------|-----------|--|
| Blindness                            |            |           |  |
| Glaucoma                             |            |           |  |
| Diabetes                             |            |           |  |
| Heart disease or high blood pressure |            |           |  |
| Cancer                               |            |           |  |
| Stroke                               |            |           |  |

**Patient Signature:**

**Provider Review (Initials & Date):**