KEY-WHITMAN EYE CENTER **PATIENT HISTORY**

NAME _____**OCCUPATION**_____ **RACE** _____**DATE**_____
DOB_____**AGE** _____ **HEIGHT**_____ **WEIGHT**_____(as stated by pt) **SEX** □ Male □ Female

MEDICAL HISTORY:

□ Anemia	□ ENT Problems	□ Mumps
□ Anxiety	□ GI Problems	□ Psychiatric Problems
□ Arthritis	□ Glaucoma	□ Pacemaker
□ Asthma	□ Gyn Problems	□ Palpitations
□ Back/Neck Problems	□ HIV	□ Prostate Problems
□ Bleeding Disorder	□ Hard of Hearing	□ Restless Leg Syndrome
□ Bronchitis	□ Heart Attack	□ Retina Problems
□ Cancer	□ Heart Disease	□ Shingles
□ Chest pain	□ Heart Murmur	□ Seizures
□ Chicken Pox	□ Hepatitis Type	□ Sinus Problems
□ Congestive Heart Failure	□ High blood pressure	□ Sleep Apnea
□ COPD	□ High Cholesterol	□ Stroke
□ Depression	□ Kidney/Bladder/Urinary Problems	□ Thyroid Problems
□ Diabetes	□ Liver Disease	□ Ulcers
□ Emphysema	□ Measles	□ Other_____

□ **HISTORY OF HEAD OR EYE TRAUMA** (please describe)_____

SURGICAL HISTORY: (list all prior surgeries to the best recollection)

_____

_____

_____

Complications with anesthesia? □ Yes □ No If yes, what is the complication? _____

FAMILY HISTORY OF OCULAR DISEASE:

□ Macular Degeneration Whom: _____
□ Glaucoma Whom: _____
□ Diabetes Whom: _____

DRUG ALLERGIES: □ No known allergies □ Latex allergy □ Sulfa allergy □ Adhesive tape
□ Medication allergy_____Reaction_____

PHARMACY NAME_____**Location**_____**Phone**_____

MEDICATIONS: If you need to add more medications, please add to the back of this form.

Drug Name	Dosage	Times per day

SOCIAL HISTORY:

Do you drink alcohol? □ Yes □ No Drinks per week? _____
Do you smoke? □ Yes □ No PPD_____ Years_____
Previous smoker? □ Yes □ No When did you quit?_____ PPD _____ Years _____