SUNY COLLEGE OF OPTOMETRY
UNIVERSITY EYE CENTER

PATIENT HISTORY

Patient Name:	MRN:
Occupation:	Date: / /
When was your last eye examination?	Date of Birth: / /

	CIRCLE ONE	
Do you wear eyeglasses?	Y	N
Do you wear contact lenses?	Y	N
Are you interested in trying contact lenses?	Y	N
Have you ever had eye surgery?	Y	N
Have you ever had an eye injury?	Y	N
Have you ever had an eye turn?	Y	N
Have you been told that you have a lazy eye or amblyopia?	Y	N
Have you been told that you have cataracts?	Y	N
Have you been told that you have glaucoma?	Y	N
Have you been told that you have any eye disease?	Y	N
Does anyone in your family have glaucoma?	Y	N
Does anyone in your family have any other eye disease?	Y	N
Do you use a computer?	Y	N

List any prescription or over-the-counter eye drops that you use:

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GENERAL MEDICAL INFORMATION

When was your last physical examination? ___________________

List any prescription or over-the-counter medications you are taking:

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Do you currently have or are being treated for any of the following problems?	CIRCLE ONE	
Cardiovascular problems / Heart problems *(e.g., chest pain or discomfort, irregular heart beat/palpitations)*	Y	N
Breathing problems *(e.g., shortness of breath, wheezing, asthma)*	Y	N
Gastrointestinal problems *(e.g., decreased appetite, nausea, vomiting)*	Y	N
Endocrine problems *(e.g., unusual thirst, appetite, or need to urinate)*	Y	N
Allergies *(e.g., environmental, medications, foods)*	Y	N
Urinary problems *(e.g., pain or discomfort, gential lesions)*	Y	N
Skin problems *(e.g., rashes, skin changes)*	Y	N
Musculoskeletal problems *(e.g., muscle weakness, joint pain or swelling, back pain)*	Y	N
Neurological problems *(e.g., balance problems, dizziness, memory difficulty)*	Y	N
Psychiatric problems *(e.g., depression, emotional changes, insomnia)*	Y	N
General Wellness *(e.g., fatigue, weakness, weight loss)*	Y	N
Ear / Nose / Throat problems *(e.g., hearing loss, vertigo, sinus problems)*	Y	N
Blood diseases *(e.g., unusual bleeding, unusual bruising)*	Y	N
Other medical conditions not noted above *(e.g., cancer, pregnancy, stroke)* SPECIFY ______________________________	Y	N
Systemic Diseases *(e.g., Diabetes, Sickle Cell, Lupus, Sarcoidosis, Asthma, MS)*	Y	N
Have you ever had any surgery?	Y	N
Does diabetes run in your family?	Y	N
Does high blood pressure run in your family?	Y	N
Do heart problems run in your family?	Y	N
Do you smoke?	Y	N
Do you drink alcoholic beverages?	Y	N
If patient is under 18 years old: Are immunizations up to date?	Y	N

REVIEWED BY	DATE
,O.D.	/ /