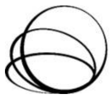

SUNY COLLEGE OF OPTOMETRY
UNIVERSITY EYE CENTER®

33 W 42nd Street
New York, NY 10036
(212) 938-4001 universityeyecenter.org

# PATIENT HISTORY

| Patient Name: | Date of Birth: | MRN: | PN: | Date: |
|---|---|---|---|---|
| **Preferred Name:** | **Assigned Sex at Birth:** | **Occupation:** | | **Last Eye Exam Date:** |

**Pronoun:**
☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Theirs ☐ Ze, Hir ☐ Other ☐ Decline to Answer

**Gender Identity:**
☐ Female ☐ Male ☐ Gender queer ☐ Transgender Male ☐ Transgender Female ☐ Other ☐ Choose Not to Disclose

| | 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 your 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 your 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:

**GENERAL MEDICAL INFORMATION**
When was your **last physical examination**?

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

| **Do you currently have or are you 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, genital 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 notes 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 |
| Are immunizations up to date? *(If patient is under 18 years old)* | Y | N |

| REVIEWED BY , O.D. | DATE / / |
|---|---|

| Patient/Guardian Name (Printed): | Patient/Guardian Signature: | DATE / / |
|---|---|---|