Asheville Eye Associates Patient History Form

Patient Name: _____ SS#: _____ Date of Birth: _____

Home Phone: _____ Referred by: _____

Primary Care Doctor: _____ Optometrist: _____

Pharmacy: _____ Pharmacy #: _____

History of Latex Allergy: ☐Yes ☐No Height: _____ Weight: _____

Race: _____ Language: _____ Ethnicity: _____

Have you or any family members had an anesthesia reaction? ☐Yes ☐No

Medication Allergies and Reactions: _____

Review of Systems

System	Yes/No	Diagnosed	Condition/Current Treatment/Surgery
Eye disease, eye injury, eye surgery	☐Yes ☐No		
Overall healthy? (fever, weight loss, other)	☐Yes ☐No		
Ears (reduced hearing or hearing loss)	☐Yes ☐No		
Nose/Mouth/Throat (sinus, sore throat)	☐Yes ☐No		
Cardiovascular (heart, vascular, hypertension, pacemaker/defibrillator)	☐Yes ☐No		
Respiratory (breathing problems, lungs, cough)	☐Yes ☐No		
Gastrointestinal (heartburn, diarrhea, vomiting, GERD, acid reflux)	☐Yes ☐No		
Neurological (numbness, weakness, stroke, headaches, paralysis)	☐Yes ☐No		
Females (Pregnant? Nursing?)	☐Yes ☐No		
Genitourinary (male or female organ problems urinary problems, kidneys)	☐Yes ☐No		
Dermatologic (skin rashes, excessive dryness rosacea)	☐Yes ☐No		
Musculoskeletal (muscle or joint problems)	☐Yes ☐No		
Rheumatoid Arthritis	☐Yes ☐No		
Diabetes/Thyroid	☐Yes ☐No		
Allergic/Immunologic	☐Yes ☐No		
Psychiatric (depression)	☐Yes ☐No		
Hematologic (bleeding tendency, anemia)	☐Yes ☐No		
Cancer (Type):	☐Yes ☐No		

Family History:

☐Yes ☐No High Blood Pressure
☐Yes ☐No Diabetes
☐Yes ☐No Glaucoma
☐Yes ☐No Cataracts
☐Yes ☐No Retinal Disease
☐Yes ☐No Other eye problems:

Social History:

Marital Status: ☐ Married ☐ Single ☐ Widowed
Currently Employed: ☐Yes ☐No
If yes, occupation: _____
Use of Tobacco/Alcohol/Drugs: ☐Yes ☐No
Comments: _____

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Current Prescribed and Over the Counter Medications including vitamins and herbal medications:

Name of Prescription/Medication	Taken for what Condition	Dosage	Frequency

Have you ever taken any of the following medications? If yes please check box

☐ Cardura ☐ Finasteride ☐ Hytrin ☐ Uroxatral ☐ Flomax ☐ Proscar

History of any major illnesses, injuries, or surgeries:

Procedure	Reason	When?

Visual Function Questions			
Please check Yes or No if you are experiencing any difficulty with the following while wearing your glasses or contacts:			
	Yes	**No**	**Comments**
Reading small print			
Reading newspaper or book			
Recognizing people when close			
Seeing steps, stairs, or curbs			
Difficulty driving at night			
Reading traffic signs, street signs			
Doing fine handiwork			
Writing checks, completing forms			
Playing games (i.e. bingo, cards)			
Taking part in sports (i.e. golf, tennis)			
Cooking/Hobbies			
Watching TV			
Bothered by glare/halos			
If yes, please describe			
Are you satisfied with your current vision?			

Patient's Signature: _____ Date: _____