

**COASTAL EYE SPECIALISTS
COMPREHENSIVE EYE AND HEALTH HISTORY**

Patient name: _____ Today's date: _____
 Place of birth: _____ Date of birth: _____
 Primary physician: _____ Referred by? _____

Yes No

Do you have glasses? If so, how old are they? _____
 Do you have contact lenses? If so, how old are they? _____
 Who normally fits your glasses? _____
 Are you pregnant or possibly pregnant? If so, when are you due? _____

OCULAR HISTORY

| Have you ever had: | <u>Yes</u> | <u>No</u> | When? |
|----------------------------|--------------------------|--------------------------|--------------|
| Intermittent vision loss | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Loss of part of vision | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Double vision | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Eye pain | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Flashes of light | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Floaters (spots in vision) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes in the eye | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular degeneration | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal detachment | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Dry eyes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Recurrent/severe infection | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Drooping eyelids | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Crossed eyes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Lazy eye | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Serious eye injury | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Eye surgery | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

FAMILY HISTORY

| In your family is there: | <u>Yes</u> | <u>No</u> | Who? |
|---------------------------------|--------------------------|--------------------------|-------------|
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cataracts before age 60 | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular degeneration | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal detachment | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinitis pigmentosa | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Anemia or sickle cell | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Migraine | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

MEDICAL HISTORY/SYSTEMS REVIEW

| Have you ever had: | <u>Yes</u> | <u>No</u> | When? |
|---------------------------|--------------------------|--------------------------|--------------|
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Migraine | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Anemia or sickle cell | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Bleeding tendency | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Breathing/lung trouble | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid disease | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Depression | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Major trauma | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Keloids | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| HIV infection | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

ARE YOU ALLERGIC TO ANY MEDICINES?

(if so, please list:)

SOCIAL HISTORY

| Do you use: | <u>Yes</u> | <u>No</u> | How much? |
|--------------------|--------------------------|--------------------------|------------------|
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Occupation: _____

Marital status:

single married divorced
 separated widowed

Number of children _____

Patient signature_____

Reviewer/Date_____