METROPOLITAN EYE CARE

Comprehensive Patient History (1 of 2)

Name:______________________________ **Date of Birth**: _______________ **Date:** _________________

Review of Systems

Do You Have?	**Yes**	**No**
Decreased vision………………..	☐	☐
Flashes………………………...	☐	☐
Abnormal sensitivity to light…….	☐	☐
Halos around lights…………..	☐	☐
Problems with glare……………..	☐	☐
Red eye………………………….	☐	☐
Eye discomfort………………….	☐	☐
Eye dryness…………………...	☐	☐
Eye itching………………………..	☐	☐
Pressure in or behind the eye…	☐	☐
Tearing of the eyes…………..	☐	☐
Discharge………………………	☐	☐
Crusting or red eyelids………..	☐	☐
Double vision……………………	☐	☐
Headaches………………………	☐	☐
Jagged lines in vision……………	☐	☐
Distortion of vision………….…….	☐	☐

Other illnesses:_____________________________

____

Other surgeries: ____________________________

____

Past Medical History

Have you ever had?	**Yes**	**No**
Eye surgery………………………	☐	☐
Eye injury…………………………	☐	☐
Serious eye infection……………	☐	☐
Lazy eye…………………………..	☐	☐
Droopy eyelid…………………….	☐	☐
Corneal disease…………………	☐	☐
Cataract…………………………	☐	☐
Retinal disorder………………….	☐	☐
Eye tumor…………………………	☐	☐
Eye turning in or out……………	☐	☐
Diabetes………………………….	☐	☐
High blood pressure……………	☐	☐
Heart disease……………………	☐	☐
Lung disease…………………….	☐	☐
Neurological disease……………	☐	☐
Thyroid disease…………………..	☐	☐
Migraine……………………………	☐	☐
Lupus……………………………..	☐	☐
Asthma……………………………	☐	☐
Stroke……………………………..	☐	☐
Glaucoma…………………………	☐	☐
Cancer……………………………	☐	☐
Cholesterol………………………	☐	☐

Comprehensive Patient History (2 of 2)

Name:______________________________ **Date of Birth**: _______________ **Date:** _________________

Family History	**Yes**	**No**
Cataracts……………………………	☐	☐
Macular Degeneration……………	☐	☐
Blindness…………………………...	☐	☐
Retinal Detachment………………	☐	☐
Glaucoma…………………………..	☐	☐
Do you wear contact lenses?…….	☐	☐

If so, please provide any information you may have:

Soft   Gas Perm.   Toric

Disposable   Extended wear

Name of Contact Lenses:

Present Prescription:

Base Curve (B.C.)

Diameter (Dia.)

Social history	**Yes**	**No**
Do you smoke……………………	☐	☐
Are you pregnant……………… …	☐	☐
Do you use a computer often… ...	☐	☐
Do you consume alcohol………. .	☐	☐
Other eye disorders…………… ..	☐	☐
Do you wear glasses……… …..…	☐	☐

If so, what purpose: Distance   Reading   Bifocal

Progressive (Varilux)   Trifocal   Half /reader

List Allergies to medications if any:

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________
6. ____________________________________
7. ____________________________________

Present Medication List: **Dosage**   **Freq.**

Are you taking Flomax?   Yes   No

1. ________________________/_____________/__________
2. ________________________/_____________/__________
3. ________________________/_____________/__________
4. ________________________/_____________/__________
5. ________________________/_____________/__________
6. ________________________/_____________/__________
7. ________________________/_____________/__________