**METRO EYE CARE**

# Comprehensive Patient History

**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

**Name**:_____ **Date of Birth**: _____ **Date:** _____

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

| **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, 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.)

If so, what purpose: Distance Reading Bifocal

Progressive (Varilux) Trifocal Half /reader

***Pharmacy Name***:_____

***Pharmacy Address***:_____

_____

***Pharmacy Number***:_____

**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. _____/_____/_____