Looking Glass Eye Center Patient History Form

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

Referred by: _____ **Optometrist:**_____

Pharmacy: _____ **Primary Care Doctor:** _____

Medications: _____

_____

Allergies to Medications: _____

_____

Have you ever had a pneumonia vaccine? : _____

Ocular History: Please circle all that apply
Cataracts, Glaucoma, Macular Degeneration, Retinal Detachment, Wrinkling of the Retina, Double Vision, Ambylopia (lazy eye), Trauma to the eye(s), Iritis (Inflammation in the eye), Other:_____

_____

Surgical History:Please list previous surgeries including eye surgery(Cataract,Laser Vision Correction, Glaucoma Surgery, Lasers): _____

_____

Review of Systems: **Please circle all that apply**
Endocrine System: Adrenal Gland Disorders, Diabetes Type I, Diabetes Type II, Hyperthyroidism, Hypothyroidism, Hypoglycemia, Prediabetes
Other:_____

Hematologic/Lymphatic: Anemia, Blood disorders, Hemachromatosis, Leukemia,
Other:_____

Cardiovascular/Heart: Hypertension, Stroke, Cholesterol, Other:_____

Neurological: Bell's Palsy, TIA, Other:_____

Ears, Nose, Throat: Sinus, Other_____

Respiratory/Lungs: Asthma, COPD, Other:_____

Stomach/Intestines: Hepatitis (A, B, C),Other:_____

Integumentary/Skin: Skin Cancer, Other:_____

Bones/Joints/Muscles: JuvenileRheumatoid Arthritis, Multiple Sclerosis, RheumatoidArthritis,

Other:_____

Allergic/Immunologic: HIV, Lupus, Seasonal Allergies, Other:_____

Psychiatric: Depression, BiPolar, Other: _____

Genitals/Kidney/Bladder: _____

Family History: Please circle all that apply in your blood related family

Glaucoma	Mother	Father	Brother	Sister	Son	Daughter
Cataracts	Mother	Father	Brother	Sister	Son	Daughter
Retina Disease	Mother	Father	Brother	Sister	Son	Daughter
Macular Degeneration	Mother	Father	Brother	Sister	Son	Daughter
Hypertension	Mother	Father	Brother	Sister	Son	Daughter
Strabismus	Mother	Father	Brother	Sister	Son	Daughter
Amblyopia	Mother	Father	Brother	Sister	Son	Daughter
Blindness/Vision Loss	Mother	Father	Brother	Sister	Son	Daughter
Diabetes	Mother	Father	Brother	Sister	Son	Daughter
Cancer	Mother	Father	Brother	Sister	Son	Daughter
Heart Disease	Mother	Father	Brother	Sister	Son	Daughter
Other:_____	Mother	Father	Brother	Sister	Son	Daughter
Other:_____	Mother	Father	Brother	Sister	Son	Daughter

Social History

Do you currently smoke? Yes No If yes, how much do you smoke per day?_____
Have you ever smoked? Yes No If yes, when did you stop: _____
Do you drink alcohol? Yes No
If yes, how much do you drink: Socially Daily Drinker Trivial(Occasional Drinker)
Do you wear glasses? Yes No
Do you wear contacts? Yes No
Have you ever worn contacts? Yes No Reason for stopping_____
Have you ever had refractive surgery? Yes No Type/When:_____
Do you use a computer: Yes No

Occupation:_____

Is there anything else you would like us to know about your eyes or your health?_____

_____

_____

_____

Patient Signature:_____ **Date:**_____