

# Barnet Dulaney Perkins Eye Center

## PATIENT HISTORY

*Thank you for completing this form. This information will assist the doctors and staff in providing quality care.*

Patient Name: _____		Date: _____	
Ht. _____	Wt. _____	Age _____	DOB _____
Race <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian		Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other (specify): _____			

<b>MEDICAL HISTORY:</b> Have you or a family member had, or do you currently have any of the following?					
<u>Systemic</u>	<u>Self</u>	<u>Family</u>	<u>Vascular</u>	<u>Self</u>	<u>Family</u>
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clotting Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Autoimmune Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Other</u>	<u>Self</u>	<u>Family</u>
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Systemic Connective Tissue Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dermatitis / Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			HIV / AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Lung</u>	<u>Self</u>	<u>Family</u>	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of Keloid Scar Formation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes:		
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	a) Cold sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	b) Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			c) Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently taking long-term corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Any other diseases, conditions or problems we should know about? _____					

<b>SURGERY HISTORY:</b> List ALL prior surgeries and year

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke?  Yes  No How many packs per day? \_\_\_\_\_ For how many years? \_\_\_\_\_  
Alcoholic beverage use?  Yes  No How much? \_\_\_\_\_ How often? \_\_\_\_\_ For how many years? \_\_\_\_\_  
Recreational drug use?  Yes  No Name of drug(s) \_\_\_\_\_

**MEDICATION HISTORY**

Have you ever taken any alpha-blocker medications such as: Flomax (tamsulosin), Hytrin (terazosin), Cardura (doxazosin), Uroxatral (alfuzosin)?  Yes  No  
Have you had problems with tranquilizers, narcotic medications or anesthetics?  Yes  No  
If yes, what was the problem? \_\_\_\_\_  
Has anyone in your family ever had a problem with tranquilizers or narcotics?  Yes  No  
Have you recently taken Acutane, Cordarone or migraine medication?  Yes  No

**PHARMACY INFORMATION**

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone \_\_\_\_\_  
Pharmacy Address: \_\_\_\_\_

**MEDICATIONS** List all medications that you are currently taking, including over-the-counter medicines or remedies

Drug Name	Strength	How often used	Drug Name	Strength	How often used

**ALLERGIES & REACTION**

List all medication, food and other items that you are allergic to.  
If you have no allergies, write "NONE".


Are you sensitive to iodine / tape / latex?  Yes  No  
If you had an allergic reaction, did you have:  
A skin rash or hives?  Yes  No  
Wheezing or trouble breathing?  Yes  No  
Hay fever or runny nose?  Yes  No

**PATIENT PRINTED NAME**

<b>STAFF SIGNATURE</b>	<b>DATE / TIME</b>	<b>PATIENT SIGNATURE</b>	<b>DATE / TIME</b>