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.

Please use Black Ink ONLY when filling out these forms.

Patient Name: _____ Date: _____

(Please print.)

Ht. _____ Wt. _____ Age _____ DOB _____ Gender: ❑ M ❑ F

Are you pregnant? ❑ Yes ❑ No

MEDICAL HISTORY: Have you or a family member had, or do you currently have any of the following?

Systemic	Self	Family	If family, who?
Anemia	❑ Yes	❑ Yes	
Bleeding Disorders	❑ Yes	❑ Yes	
Sickle Cell	❑ Yes	❑ Yes	
Clotting Disorders	❑ Yes	❑ Yes	
Arthritis	❑ Yes	❑ Yes	
Diabetes	❑ Yes	❑ Yes	
Thyroid	❑ Yes	❑ Yes	
Autoimmune Disorders	❑ Yes	❑ Yes	
Fibromyalgia	❑ Yes	❑ Yes	
Systemic Connective Tissue Diseases	❑ Yes	❑ Yes	
Dermatitis / Eczema	❑ Yes	❑ Yes	

Lung	Self	Family	If family, who?
Asthma	❑ Yes	❑ Yes	
Emphysema	❑ Yes	❑ Yes	
Bronchitis	❑ Yes	❑ Yes	
Pneumonia	❑ Yes	❑ Yes	

Vascular	Self	Family	If family, who?
Congestive Heart Failure	❑ Yes	❑ Yes	
Heart Attack	❑ Yes	❑ Yes	
Heart Disease	❑ Yes	❑ Yes	
High Cholesterol	❑ Yes	❑ Yes	
High Blood Pressure	❑ Yes	❑ Yes	
Stroke	❑ Yes	❑ Yes	
Pacemaker	❑ Yes	❑ Yes	
Defibrillator	❑ Yes	❑ Yes	

Other	Self	Family	If family, who?
Hepatitis	❑ Yes	❑ Yes	
HIV / AIDS	❑ Yes	❑ Yes	
Seizures	❑ Yes	❑ Yes	
History of Keloid Scar Formation?	❑ Yes	❑ Yes	
Herpes:			
a) Cold sores	❑ Yes	❑ Yes	
b) Shingles	❑ Yes	❑ Yes	
c) Other	❑ Yes	❑ Yes	

OCULAR HISTORY ***Do you wear: ❑ Glasses ❑ Contacts ❑ Over-the-Counter Reading Glasses***

	Self	Family	If family, who?
Keratoconus	❑ Yes	❑ Yes	
Amblyopia / Strabismus	❑ Yes	❑ Yes	
Blindness	❑ Yes	❑ Yes	
Cataract	❑ Yes	❑ Yes	
Glaucoma	❑ Yes	❑ Yes	
Macular Degeneration	❑ Yes	❑ Yes	
Retinal Detachment	❑ Yes		
Eye Injury / Trauma	❑ Yes		
Past RK, PRK or LASIK	❑ Yes		
Eye or Lid surgery	❑ Yes		
Dry Eye Syndrome	❑ Yes		
Eye Allergies	❑ Yes		

Patient Name: _____ Date: _____
(Please print.)

Are you currently taking long-term corticosteroids? ❑ Yes ❑ No
Any other diseases, conditions or problems we should know about? _____

SURGERY HISTORY: List **ALL** prior surgeries and year

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

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

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

ALLERGIES	REACTION

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

SOCIAL HISTORY:

Do you use tobacco? ❑ Yes ❑ No Usage per day? _____ How many years?_____
*If you quit, when?*_____
Alcoholic beverage use? ❑ Yes ❑ No How much?____ How often?____ How many years?_____
Caffeine use? ❑ Yes ❑ No How much? _____ per day?
Recreational drug use? ❑ Yes ❑ No ❍ *Current or* ❍ *Former* Name of drug(s) _____
Have you ever had bed bugs in your home? ❑ Yes ❑ No If yes, when? _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Phone _____
Pharmacy Address:

PATIENT SIGNATURE	DATE	STAFF SIGNATURE	DATE / TIME