Collin Creek Eye Clinic
MEDICAL HISTORY FORM

PATIENT HISTORY

Patient's last name:		First:		Middle Int:	Today's Date:	8/21/2009

List all medications that you are currently taking (including oral contraceptives, aspirin, over the counter medications):

Are you allergic to any medications? ☐ Yes ☐ No (List medications):

Have you had :	☐ Eye Surgery	☐ Refractive/Laser Surgery	☐ Eye Trauma	☐ Medical Treatment for your eye(s)		
Do you have:	☐ Crossed eyes	☐ Drooping eye	☐ "Lazy eye"	☐ Glaucoma	☐ Retinal Disease	☐ Cataracts

Are you pregnant or nursing?	☐ Yes	☐ No	Do you wear glasses?	☐ Yes ☐ No	How old are your current lenses?
Do you wear contacts?	☐ Yes	☐ No	How old are your current lenses?		

What type of contact lenses do you currently use?	☐ Rigid/Gas Permeable	☐ Soft	☐ Soft Toric	☐ Bifocal	☐ Disposable	☐ Other

Are you interested in Contact Lenses or Laser/Refractive surgery? ☐ Yes ☐ No

FAMILY HISTORY

Please provide your family's medical history for the following conditions: (parents, grandparents, siblings, children)

	Yes	No	Not Sure	Relationship to You		Yes	No	Not Sure	Relationship to You
Blindness	☐	☐	☐		Arthritis	☐	☐	☐	
Cataract	☐	☐	☐		Cancer	☐	☐	☐	
Crossed eye	☐	☐	☐		Diabetes	☐	☐	☐	
Glaucoma	☐	☐	☐		High Blood Pressure	☐	☐	☐	
Macular Degeneration	☐	☐	☐						

SOCIAL HISTORY

This information is kept strictly confidential. If you would prefer, you may discuss this particular information directly with Dr. Pattni.

☐ I would prefer to discuss my social history directly with Dr. Pattni.

Do you drive? ☐ Yes ☐ No	Do you use tobacco products? ☐ Yes ☐ No	Do you drink alcohol? ☐ Yes ☐ No	
Do you use illegal drugs ☐ Yes ☐ No	Have you been exposed to or infected with:	☐ HIV ☐ Gonorrhea ☐ Hepatitis	☐ Syphilis

(Continue to next page)

REVIEW OF SYSTEMS

Do you currently have or have you ever had problems in the following areas:

Constitutional			**Ears, Nose, Throat and Mouth**			**Endocrine**			**Respiratory**		
Fever	☐ Yes	☐ No	Allergies/ Hay Fever	☐ Yes	☐ No	Thyroid	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Weight gain or loss	☐ Yes	☐ No	Sinus Congestion	☐ Yes	☐ No	Other Glands	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No
Neurological			**Allergic, Immunologic/Psychiatric**			**Vascular /Cardiovascular**			**Gastrointestinal**		
Head-aches	☐ Yes	☐ No	Any Conditions	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Migraines	☐ Yes	☐ No				Heart Pain	☐ Yes	☐ No			
						Blood Pressure	☐ Yes	☐ No			
Lymphatic/Hematological			**Genitourinary**			**Bones/Joints/Muscles**			**Integumentary**		
Blood Disorder	☐ Yes	☐ No	Kidney	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Skin	☐ Yes	☐ No
			Bladder	☐ Yes	☐ No						
Eyes											
Loss of vision	☐ Yes	☐ No	Distortion	☐ Yes	☐ No	Sandy/ Gritty Feel	☐ Yes	☐ No	Foreign Body Sensation	☐ Yes	☐ No
Blurry Vision	☐ Yes	☐ No	Double Vision	☐ Yes	☐ No	Itching	☐ Yes	☐ No	Excess Tearing	☐ Yes	☐ No
Light Sensitive	☐ Yes	☐ No	Chronic Infection	☐ Yes	☐ No						

IF YOU ANSWERED "YES TO ANY OF THE ABOVE OR HAVE A CONDITION NOT LISTED ABOVE, PLEASE EXPLAIN BELOW…

Reviewed by Doctor

Date