ROS

The Eye Institute of Utah

Account # _____

Today's Date: _____

PATIENT HISTORY FORM

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

Primary Care Physician: _____ **Optometrist:** _____

Cardiologist: _____ **Endocrinologist:** _____

Pharmacy: _____ **Pharmacy Phone #** (_____)_____

History of Latex Allergy? ☐ YES ☐ NO **Have you or any family members had an anesthesia reaction?** ☐ YES ☐ NO

Medication Allergies & Reactions: _____ **Occupation:** _____

Medical History

Do you now, or have you ever had:	Yes/No	Current Treatment/ Previous Surgery	When?
Diabetes (Type)	☐ Yes ☐ No		
Heart Disease	☐ Yes ☐ No		
Pacemaker / Defibrillator ☐ Yes ☐ No			
High Blood Pressure	☐ Yes ☐ No		
High Cholesterol	☐ Yes ☐ No		
Kidney Disease (Dialysis ☐ Yes ☐ No **)**	☐ Yes ☐ No		
Liver Disease	☐ Yes ☐ No		
Stroke	☐ Yes ☐ No		
Anemia	☐ Yes ☐ No		
Asthma or Lung Disease	☐ Yes ☐ No		
Thyroid Disease:	☐ Yes ☐ No		
☐ **Overactive** ☐ **Underactive**			
Cancer or Tumor (Type)	☐ Yes ☐ No		
Arthritis (Type)	☐ Yes ☐ No		
Other Medical Problems or Surgeries:	☐ Yes ☐ No		

FAMILY HISTORY:

			Relationship
☐ Yes	☐ No	High blood pressure	_____
☐ Yes	☐ No	Diabetes	_____
☐ Yes	☐ No	Cancer	_____
☐ Yes	☐ No	Glaucoma	_____
☐ Yes	☐ No	Cataracts	_____
☐ Yes	☐ No	Retinal disease	_____
☐ Yes	☐ No	Macular degeneration	_____
☐ Yes	☐ No	Keratoconus	_____

SOCIAL HISTORY:

Use of Tobacco: ☐ Current ☐ Former ☐ Never

Amount: _____

Alcohol: ☐ Yes ☐ No

Amount: _____

Drugs: ☐ Yes ☐ No

Caffeine: ☐ Yes ☐ No

☐ Yes ☐ No Other eye/medical problems _____

Please list Prescribed and Over-The-Counter Medications, including vitamins and supplements, you are currently taking:

Name of Medication	Reason for taking	Name of Medication	Reason for taking

Have you ever taken any of the following medications? If Yes, please check box

☐ **Cardura** ☐ **Finasteride** ☐ **Hytrin** ☐ **Uroxatral** ☐ **Flomax** ☐ **Proscar** ☐ **Jalyn**

Patient Name: _____ Acct#: _____

Ocular History

Do you currently have, or have you ever had:	Yes/No	Eye	Diagnosis	Current Treatment/ Previous Surgery	When?
Eye disease	☐ Yes ☐ No				
Eye Injury	☐ Yes ☐ No				
Eye Surgery	☐ Yes ☐ No				

REVIEW OF SYSTEMS - Do you *currently* have any problems in the following areas?

System	Yes/No	System	Yes/No
Constitutional: Fever	☐ Yes ☐ No	**Neurological**: Dizziness	☐ Yes ☐ No
Weight: ☐ Loss ☐ Gain	☐ Yes ☐ No	Headache	☐ Yes ☐ No
Cardiovascular: Chest Pressure or Discomfort	☐ Yes ☐ No	Numbness of Extremities	☐ Yes ☐ No
Irregular Heartbeat/Palpitations	☐ Yes ☐ No	**Musculoskeletal:** Muscle Weakness	☐ Yes ☐ No
Metabolic/ Intolerant to: ☐ Cold ☐ Heat	☐ Yes ☐ No	Joint Swelling/Arthritis	☐ Yes ☐ No
Endocrine: Excessive Thirst (***polydipsia***)	☐ Yes ☐ No	**Respiratory:** Difficulty Breathing (***dyspnea***)	☐ Yes ☐ No
Urinating more than usual (***polyuria***)	☐ Yes ☐ No	Cough	☐ Yes ☐ No
Integumentary/Skin:		**Genitourinary:** Painful Urination (***dysuria***)	☐ Yes ☐ No
Dry Skin	☐ Yes ☐ No	**Psychiatric:** Depressed Mood	☐ Yes ☐ No
Rash	☐ Yes ☐ No	**Hematologic/Lymphatic:**	
ENT: Hearing Loss	☐ Yes ☐ No	Easily: ☐ Bleeds & /or ☐ Bruises	☐ Yes ☐ No
Sinus Problems	☐ Yes ☐ No	Swollen Lymph Nodes (***lymphadenopathy***)	☐ Yes ☐ No
Sore Throat	☐ Yes ☐ No	**Allergic/Immunologic:**	
Gastrointestinal: Abdominal pain	☐ Yes ☐ No	☐ Food allergies ☐ Seasonal allergies	☐ Yes ☐ No
Heartburn	☐ Yes ☐ No		
Vomiting	☐ Yes ☐ No	**FEMALES**: Are you Pregnant or Nursing?	☐ Yes ☐ No

VISUAL FUNCTION QUESTIONS

Please check Yes or No if you are having any difficulty with the following while wearing your glasses or contacts (if applicable)

	Yes	No	Comments
Reading small print			
Reading newspaper or book			
Recognizing people when close			
Seeing steps, stairs, or curbs			
Difficulty driving on bright sunny days			
Difficulty driving at night			
Reading traffic signs, street signs			
Doing fine handiwork			
Writing checks, completing forms			
Playing games (i.e. bingo, cards)			
Taking part in sports (i.e. golf, tennis)			
Cooking/Hobbies			
Watching TV			
Bothered by glare/halos			
If yes, please describe			
Are you satisfied with your current vision?			

Please list all individuals you authorize to receive information about your care:

Individual	Relationship	Phone

Patient's Signature:_____ Date:_____