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# PATIENT HISTORY FORM

PATIENT ACCT # \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ DATE OF LAST EYE EXAM: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ CURRENT EYE DOCTOR: \_\_\_\_\_

CURRENT EYE PROBLEM: \_\_\_\_\_

DO YOU HAVE ANY ALLERGIES? If so please list: \_\_\_\_\_

HAVE YOU EVER WORN GLASSES?      YES      NO

HAVE YOU EVER WORN CONTACTS?      YES      NO

WHAT IS YOUR FAVORITE SPORT OR HOBBY? \_\_\_\_\_

WHO MAY WE THANK FOR YOUR REFERRAL? \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_

SUBSTANCE ABUSE? \_\_\_\_\_ HOW OFTEN? \_\_\_\_\_

DO YOU DRINK ALCOHOL? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_

**HAVE YOU NOTICED ANY:**

- Loss of vision
- Pain behind eyes
- Flashes of light
- Spots before eyes
- Difficulty reading
- Double vision
- Excessive tearing
- Eye infection

**HAVE YOU EVER BEEN TOLD THAT YOU HAVE:**

- Cataracts
- Glaucoma
- Retinal disease
- Lazy eye
- Crossed eyes
- Macular Degeneration
- Eye Injury

**HAVE YOU EVER BEEN TREATED FOR:**

- Diabetes
- High blood pressure
- Cancer
- Migraine
- HIV / AIDS
- TB
- Heart disease
- Arthritis
- Stroke
- Thyroid disease
- Hepatitis
- Seizures

**HAVE ANY MEMBERS OF YOUR FAMILY EVER HAD:**

- Glaucoma
- Cataracts
- Retinal Disease
- Glaucoma
- Poor vision
- Lazy eye
- Heart Disease
- Macular Degeneration
- Diabetes
- High Blood Pressure
- Stroke

DO YOU CURRENTLY TAKE ANY "EYE" MEDICATIONS? If yes, please list: \_\_\_\_\_

DO YOU CURRENTLY TAKE ANY MEDICATIONS? If yes, please list: \_\_\_\_\_

HAVE YOU EVER HAD ANY MAJOR SURGERY? If yes, please give further details: \_\_\_\_\_

**REVIEWED AND UPDATED BY:**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ DR. REVIEW: \_\_\_\_\_

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