CLEVELAND EYE CLINIC PATIENT HISTORY

Please check each item either YES or No. Some insurance companies require that we have this form completed and updated yearly. Also, the doctor can better serve you with a complete picture of your health. Thanks. *Let us know if you filled one out recently.*

NAME _____ Date of Birth ___/___/____ Today's Date ___/___/___

Do you have a LIVING WILL? __YES __NO

DO YOU HAVE A HISTORY OF ANY PROBLEMS IN THE FOLLOWING AREAS? CHECK *NO, PAST OR PRESENT*. What about blood relatives? (Use F (father) M (mother) B (brother) S (sister).

	YES (present)	YES (past)	NEVER	EXPLAIN	BLOOD RELATIVES
RESPIRATORY (Bronchitis, Sinusitis)					
FEVER/WEIGHT LOSS (unexplained)					
HEART prob. (pacemaker,heart attack)					
LUNGS/breathing (asthma, emphysema)					
MUSCLES/BONES (arthritis, etc)					
SKIN PROBLEMS (eczema, psoriasis)					
NERVES/BRAIN (migraines, STROKE)					
ENDOCRINE(thyroid,pituitary,pancreas)					
BLOOD/LYMPH glands (Leukemia, etc)					
EARS/NOSE/MOUTH					
CANCER (state type)					
H.I.V. (Aids)					
HIGH BLOOD PRESSURE					
DIABETES (state type)					
SURGERIES (other than eye)					
(surgeries continued)					
ANY OTHER DISEASES?					

HAVE ANY OF YOUR BLOOD RELATIVES HAD ANY OF THESE?

	NO	YES
GLAUCOMA		
LAZY EYES		
CROSSED EYES		

	NO	YES
RETINAL DETACHMENT		
CATARACTS		
MACULAR DEGENERATION		

ARE YOU HAVING (or have you ever had) ANY OF THE FOLLOWING?

	NO	YES	EXPLAIN (AND APPROXIMATE DATE)
EYE SURGERY			
EYE INJURY			
GLAUCOMA			
LAZY EYE (Poor childhood vision)			
FLASHING LIGHTS/FLOATERS			
DOUBLE VISION			
DECREASED/BLURRED VISION			
RETINAL DETACHMENT			
OTHER EYE DISEASES			

DO YOU WEAR GLASSES? NO ___ YES___ CONTACTS? NO ___ YES ___ CL Brand _____

DO YOU HAVE PROBLEMS WITH NORMAL DAILY ROUTINE DUE TO VISION? NO ___ YES ___

DO YOU SMOKE? NO ___ YES___ DRINK ALCOHOL? NO ___ YES ___ USE NON-PRESCRIBED DRUGS? NO ___ YES ___

I am NOT allergic to any medications ☐ I AM ALLERGIC TO: _____

LIST ALL MEDICATIONS (AND DOSAGE) YOU ARE TAKING: _____

OFFICE USE ONLY: History Reviewed (date)	No changes noted by patient	Changes as listed here:	Reviewed by: (tech/dr) initials