ZDENEK EYE INSTITUTE

Patient Health History

Welcome to our Practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name: ____ Age: ________ Date: _______________________________

❑ Male ❑ Female Primary Care Physician: ______________________________________ City: _________________________

Eye History

Have you ever had the following eye conditions? (Check "no" or "yes", leave blank if uncertain) **Explanation**

Condition	No	Yes	Explanation
Glaucoma, Cataracts, Etc................	❑ No	❑ Yes	
Loss of Vision	❑ No	❑ Yes	
Blurred Vision	❑ No	❑ Yes	
Fluctuating Vision	❑ No	❑ Yes	
Distorted Vision	❑ No	❑ Yes	
Loss of Side Vision	❑ No	❑ Yes	
Double Vision	❑ No	❑ Yes	
Dryness	❑ No	❑ Yes	
Mucous Discharge	❑ No	❑ Yes	
Redness	❑ No	❑ Yes	
Lazy Eye/Crossed Eye	❑ No	❑ Yes	
Sandy or Gritty	❑ No	❑ Yes	
Itching	❑ No	❑ Yes	
Burning	❑ No	❑ Yes	
Foreign Body Sensation	❑ No	❑ Yes	
Excess Tearing	❑ No	❑ Yes	
Glare/Light Sensitivity	❑ No	❑ Yes	
Pain or Soreness	❑ No	❑ Yes	
Infection	❑ No	❑ Yes	
Tired Eyes	❑ No	❑ Yes	
Drooping Eyelid	❑ No	❑ Yes	
Other	❑ No	❑ Yes	

Previous Hospitalizations/Surgeries/Serious Illnesses

	When?	Hospital, City, State
____	________________	________________
____	________________	________________

Medications: (Include Non-Prescription) ____

____

Have you ever taken Fen-Phen/Redux? Yes No Have you ever taken Flomax? Yes No

Patient Social History: (Check Appropriate Answer)

Use of Alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily, If daily, how much per day? _____________

Use of Tobacco: ❑ Never ❑ Previously, but not in the past ______ years(s) ❑ Yes, If yes: Current packs/day:______

Do you have visual difficulty when driving? ❑ Yes ❑ No

Do you currently wear: ❑ Contact Lenses ❑ Glasses ❑ Neither

Have you considered: ❑ LASIK ❑ Contact Lenses ❑ Cosmetic Eyelid Surgery ❑ SSP (Presbyopia Surgery)

Other consideration (not listed above)? ____

Do you have any of the following hobbies or interests?

❑ Water Sports	❑ Jogging/Running	❑ Bicycling	❑ Reading
❑ Watching TV / Movies	❑ Tennis	❑ Golf	❑ Computer
❑ Driving	❑ Walking	❑ Aerobics	❑ Gym Workout
❑ Scrapbooking	❑ Sewing	❑ Needlework	❑ Knitting / Crochet

Others (not listed): ____

____

Family Medical History:

	Age	Medical/Eye Diseases	If Deceased, Cause of Death
Father	____________	______________________________________	______________________________________
Mother	____________	______________________________________	______________________________________
Siblings	____________	______________________________________	______________________________________
	____________	______________________________________	______________________________________
Spouse	____________	______________________________________	______________________________________
Children	____________	______________________________________	______________________________________
	____________	______________________________________	______________________________________

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

- Good general health lately .... ❑ No ❑ Yes
- Recent weight change .... ❑ No ❑ Yes
- Fever .... ❑ No ❑ Yes
- Fatigue .... ❑ No ❑ Yes

Ears/Nose/Mouth/Throat

- Earaches or drainage .... ❑ No ❑ Yes
- Chronic sinus prob. or rhinitis.......... ❑ No ❑ Yes
- Fever .... ❑ No ❑ Yes
- Fatigue .... ❑ No ❑ Yes

Neurological

- Numbness or tingling sensation..... ❑ No ❑ Yes
- Paralysis .... ❑ No ❑ Yes
- Headaches .... ❑ No ❑ Yes
- Light headed or dizzy .... ❑ No ❑ Yes
- Convulsions or seizures .... ❑ No ❑ Yes
- Tremors .... ❑ No ❑ Yes
- Head injury .... ❑ No ❑ Yes

Hematologic/Lymphatic

- Anemia.. ❑ No ❑ Yes
- Bleeding or bruising tendency....... ❑ No ❑ Yes
- Slow to heal after cut .... ❑ No ❑ Yes
- Phlebitis .... ❑ No ❑ Yes
- Past transfusion .... ❑ No ❑ Yes
- Enlarged glands .... ❑ No ❑ Yes

Diabetes .... ❑ No ❑ Yes

High Blood Pressure .... ❑ No ❑ Yes

Respiratory

- Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? .... ❑ No ❑ Yes
- Shortness of breath..................... ❑ No ❑ Yes
- Wheezing .... ❑ No ❑ Yes
- Spitting up blood........................... ❑ No ❑ Yes
- Tuberculosis .... ❑ No ❑ Yes

Gastrointestinal

- Loss of appetite .... ❑ No ❑ Yes
- Change in bowel movements ...... ❑ No ❑ Yes
- Frequent diarrhea .... ❑ No ❑ Yes
- Nausea or vomiting .... ❑ No ❑ Yes
- Painful bowel movements or constipation .... ❑ No ❑ Yes
- Rectal bleeding or blood in stool ...... ❑ No ❑ Yes
- Abdominal pain .... ❑ No ❑ Yes

Psychiatric

- Memory loss or confusion .... ❑ No ❑ Yes
- Depression .... ❑ No ❑ Yes
- Nervousness .... ❑ No ❑ Yes
- Insomnia .... ❑ No ❑ Yes

Cardiovascular

- Heart trouble................................. ❑ No ❑ Yes
- Chest pain or angina pectoris ...... ❑ No ❑ Yes
- Palpitation .... ❑ No ❑ Yes
- Shortness of breath when walking or lying down .... ❑ No ❑ Yes
- Swelling of feet, ankles or hands .... ❑ No ❑ Yes

Musculoskeletal

- Joint pain .... ❑ No ❑ Yes
- Joint stiffness or swelling .... ❑ No ❑ Yes
- Muscle pain or cramps .... ❑ No ❑ Yes
- Weakness pain or cramps .... ❑ No ❑ Yes
- Back pain .... ❑ No ❑ Yes
- Cold extremities .... ❑ No ❑ Yes
- Difficulty in walking .... ❑ No ❑ Yes

Allergic/Immunologic

History of skin reaction or other adverse reaction to:

- Penicillin or other antibiotics......... ❑ No ❑ Yes
- Morphine, Demerol, or other narcotics .... ❑ No ❑ Yes
- Novocain or other anesthetics .... ❑ No ❑ Yes
- Aspirin or other pain remedies .... ❑ No ❑ Yes
- Tetanus antitoxin or other serums .... ❑ No ❑ Yes
- Latex .... ❑ No ❑ Yes

Other drugs/medications: ______________
____
____
____

Known food allergies: _______________
____
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________________ Signature of Patient or Guardian if Minor

______________________ Date

Doctor's Review

______________________________________ Signature of Doctor

______________________ Date