



Bluegrass Eye Center

Patient History

Name _____ Date _____

Date of Birth _____ Age _____ Family Doctor _____

Occupation _____

Please indicate whether YOU have a history of the following by checking "YES" or "NO" next to each item.

Medical History

Yes No

- Diabetes
- High blood pressure
- Lung disease (e.g. asthma, emphysema)
- Heart disease / murmur
- Stroke
- Arthritis
- Sinus
- Thyroid disease
- Headaches / Migraines
- Cancer
- HIV positive / AIDS
- Hepatitis
- Allergic to penicillin
- Allergic to sulfa
- Allergic to codeine
- Allergic to aspirin
- Allergic to latex
- Allergic to _____
- Do you smoke?
- Do you use alcohol?
- Are you currently pregnant?
- Recent weight loss?

Eye History

Yes No

- Glaucoma
- Cataract
- Retinal problems
- Double vision
- Eye surgery
- Other _____
- _____
- _____
- Do you wear glasses?
- Do you wear contact lenses?

Surgical History

Yes No

- Heart
- Lung
- Vascular
- Neurosurgery
- Other _____

Other Medical History _____

Is there a history of any of the following in YOUR FAMILY?

Family History

Yes No

- Glaucoma
- Diabetes
- Cataract
- Lazy or crossed eyes

Yes No

- Retinal problems
- Blindness
- Other _____

Please list any medications you are taking, including eye drops, and give the dosage for each.

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Patient Signature: _____