SUMMIT EYE CLINIC ~ PATIENT HISTORY FORM

Last Name: _____ **First Name:** _____

Birth Date: _____/_____/_____ **SS #:** _____-_____-_____

Race: (circle one) **White** **Amer Indian/Alaska Native** **Asian** **Black/African Amer** **Native Hawaiian/Other Pacific Islander**

Ethnicity: (circle one) **Hispanic/Latino** **Not Hispanic/Latino**

Pref Language: (circle one) **Arabic** **English** **French** **German** **Italian** **Polish** **Russian** **Spanish** **Amer Sign** **Undetermined**

Status: (circle one) **Student** **Employed** **Retired** **Other**

PAST, FAMILY & SOCIAL HISTORY

Self – Past Ocular History

- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Surgery
- ☐ Other _____

Self – Past Medical History

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Other _____

Social History

Occupational Visual Needs: _____

Hobbies: _____

Sports / Recreation: _____

Other Special Visual Needs: _____

Family – Past Ocular History

- ☐ Cataract (circle relationship)
  Father PGF PGM
  Mother MGF MGM Sibling
- ☐ Glaucoma (circle relationship)
  Father PGF PGM
  Mother MGF MGM Sibling
- ☐ Macular degeneration (circle relationship)
  Father PGF PGM
  Mother MGF MGM Sibling
- ☐ Other _____

Family – Past Medical History

- ☐ Hypertension (circle relationship
  Father PGF PGM
  Mother MGF MGM Sibling
- ☐ Diabetes (circle relationship)
  Father PGF PGM
  Mother MGF MGM Sibling
- ☐ Other _____

REVIEW OF SYSTEMS

Allergic/Immunologic

- ☐ Drug Allergy
- ☐ Environmental Allergy
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Other: _____

Eyes

- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Surgery
- ☐ Inflamatory Disorders
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Other: _____

Musculoskeletal

- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- ☐ Other: _____

Cardiovascular

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Vascular Disease
- ☐ High Cholesterol
- ☐ Other: _____

Gastrointestinal

- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ Other: _____

Neurological

- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Alzheimers
- ☐ Parkinsons
- ☐ Cerebrovascular
- ☐ Other: _____

Constitutional

- ☐ Developmental Disability
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other: _____

Genitourinary

- ☐ STD, viral herpetic, chlamydia
- ☐ Other: _____

Psychiatric

- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia
- ☐ Other: _____

Ear, Nose, Mouth, Throat

- ☐ Upper Resp. Tract Infection
- ☐ Ear ache
- ☐ Sore Throat
- ☐ Ringing/Tinitis
- ☐ Other: _____

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Leukemia
- ☐ Other: _____

Respiratory

- ☐ Smoke
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other: _____

Endocrine

- ☐ Non-insulin Dependent Diabetes
- ☐ Insulin Dependent Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other: _____

Integumentary

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other: _____

PATIENT DRUG ALLERGIES OR SENSITIVITIES:

_____

_____

_____

☐ **"I have no drug allergies"**

PAST MEDICAL/SURGICAL HISTORY

Year	Illness / Operations / Accidents / Hospitalizations / Childhood Diseases	Where Treated	Physician

Pregnant: Yes____ No____ **Currently Nursing: Yes____ No____**

Date of last complete physical examination ___/___/___ blood tests ___/___/___ cholesterol tests ___/___/___ diabetes ___/___/___

☐ **"I do not take any prescription or over the counter medications"**

Prescription Medications ☐ **See attached list of medications**

Drug Name	Strength	How Often / When Taken

Over The Counter Medications / Vitamins / Supplements / Natural Herbs

Drug Name	Strength	How Often / When Taken

I AUTHORIZE the following individual(s) to obtain information regarding my care, including but not limited to my diagnosis, treatment, appointment dates and times, and to pick up contact lenses or glasses.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I understand this achknowledgment and release will remain in effect until written notice is given.

Signature _____ Date _____

ASSIGNMENT AND RELEASE

I authorize and consent to the examination and treatment of the above patient. I certify that the above information is correct.

Responsible Party Signature _____ Date _____

Responsible Party Signature _____ Date _____

Responsible Party Signature _____ Date _____

Responsible Party Signature _____ Date _____

Responsible Party Signature _____ Date _____

Responsible Party Signature _____ Date _____

Dana S. McGuire, OD #3052-35 **Randy J. Prestash, OD #1780-35** **Scott R. Hacker, OD #3575-35**