

MILAUSKAS EYE INSTITUTE  
PATIENT HEALTH HISTORY

Date: \_\_\_\_\_  
Reason for your visit today \_\_\_\_\_  
When did your eye problem begin? \_\_\_\_\_  
Do you wear glasses? \_\_\_\_\_ How old is your present eyeglass prescription? \_\_\_\_\_  
Are you bothered by bright light or reflections? \_\_\_\_\_ Do you wear bifocals? \_\_\_\_\_  
Do you wear trifocals? \_\_\_\_\_ Do you wear progressives (no line)? \_\_\_\_\_ How many pairs  
of prescription glasses do you currently use? \_\_\_\_\_ How much time do you spend on the  
computer? \_\_\_\_\_  
What feature do you like most about your current glasses? \_\_\_\_\_  
Do you wear contacts? \_\_\_\_\_ What type? \_\_\_\_\_ How old are they? \_\_\_\_\_  
List all medications that you take, including vitamins \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you live alone? \_\_\_\_\_ Do you drive? \_\_\_\_\_ If not, when did you stop driving? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Amount per day \_\_\_\_\_ Do you drink? \_\_\_\_\_ Amount per day \_\_\_\_\_  
List any known allergies to medications \_\_\_\_\_  
List all past eye surgeries (including eye surgeries and lasers) and approximate dates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any additional hospitalizations with approximate date and reasons \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your last medical examination? \_\_\_\_\_ Doctor's name \_\_\_\_\_  
When was your last eye exam? \_\_\_\_\_ Doctor's name \_\_\_\_\_

Answer yes or no to the following questions

Conditions in your family history (blood relative – father, mother, brother or sister)

|                     |                         |                    |                          |
|---------------------|-------------------------|--------------------|--------------------------|
| ___ Allergies       | ___ Asthma              | ___ Blindness      | ___ Cancer               |
| ___ Diabetes        | ___ Cataracts           | ___ Glaucoma       | ___ Macular degeneration |
| ___ Lazy eye        | ___ Turned eye          | ___ Migraines      | ___ Retinal disease      |
| ___ Hay fever       | ___ Thyroid condition   | ___ Skin condition | ___ Tuberculosis         |
| ___ Heart Condition | ___ High blood pressure | ___ Other          | _____                    |

Conditions that you have now or have had in the past

|                          |                         |                          |                          |
|--------------------------|-------------------------|--------------------------|--------------------------|
| ___ Angina               | ___ Arthritis           | ___ Asthma               | ___ Blackouts            |
| ___ Blood disease        | ___ Bowel disease       | ___ Cancer               | ___ Diabetes             |
| ___ Hepatitis            | ___ Drug dependency     | ___ Emotional problems   | ___ Heart condition      |
| ___ HIV positive         | ___ High blood pressure | ___ Migraines            | ___ Thyroid disease      |
| ___ Seizures             | ___ Stroke              | ___ Tuberculosis         | ___ Sinus problems       |
| ___ Skin Disease         | ___ Bronchitis          | ___ Irregular heart beat | ___ Urinary difficulties |
| ___ Blindness            | ___ Cataract            | ___ Color Blindness      | ___ Diabetic eye disease |
| ___ Dry eye              | ___ Eye injury          | ___ Glaucoma             | ___ Lazy eye             |
| ___ Macular degeneration |                         | ___ Retinal detachment   |                          |
| ___ Retinal disease      |                         | ___ Turned eye           |                          |
| ___ Other                |                         |                          | _____                    |



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