

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			_____
