PATIENT HISTORY FORM

Name ____Date_________
D.O.B.______/____/______
Address ___________________________City ______________Zip______
Home Phone or Cell #________________E-Mail_____________________
Employer/Occupation____
VISION INSURANCE ___________________________SS#______________
Date of Last Eye Exam ________________By Whom_________________
Date of Last Medical Exam ___________Name of MD.________________
Reason For Today's Exam____________________________________

____

Do You Wear Glasses? __NO __YES How Old? ______Type___________
Do You Wear Contacts? __NO __YES How Old ?____Brand____________
Type of Contacts __GP__SOFT__TORIC__BIFOCAL__OTHER________
Are Your Contacts Comfortable All Day Long?____________________
Do You Have Difficulty Seeing Far Away or Close Up?_______________
Do You Suffer From Headaches? __NO__YES, How often______________
Current Medications_______________________________________
Allergies____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased):

DISEASE/CONDITION

Blindness……………………..___NO___YES _____
Cataract……………………..___NO___YES _____
Crossed Eyes………………..___NO___YES _____
Glaucoma……………………___NO___YES _____
Macular Degeneration………___NO___YES _____
Retinal Detachment…………___NO___YES _____
Arthritis………………………..___NO___YES _____
Cancer………………………..___NO___YES _____

Diabetes………………___NO___YES____
Heart Disease…………___NO___YES____
High Blood Pressure…___NO___YES____
Kidney Disease……….___NO___YES____
Lupus…………………..___NO___YES____
Thyroid Disease………___NO___YES____
Other_________________________

SOCIAL HISTORY

This information is kept strictly confidential.

Do You Smoke? ___NO ___Yes If Yes, Type/Amt/ How Long_____________
Do You Drink? ___NO ___YES If Yes, Type/Amt/How Long_____________
Do You Use Drugs ___NO ___Yes If Yes, Type/Amt/How Long___________

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

CONSTITUTIONAL

Fever, Weight Loss/Gain……………___NO__YES

INTEGUMENTARY (SKIN)……….___NO__YES

Dr. Epstein reviewed this form with patient __________________Date________

NEUROLOGICAL

Headaches………………__NO__YES
Migraines………………..__NO__YES
Seizures…………………..__NO__YES

***EYES**

Distorted Vision/Halos…__NO__YES
Loss of Side Vision………__NO__YES
Double Vision…………..__NO__YES
Dryness…………………._NO__YES
Mucous Discharge…….__NO__YES
Redness…………………__NO__YES
Sandy/Gritty Feeling…..__NO__YES
Loss of Vision…………..__NO__YES
Blurred Vision…………..__NO__YES
Tired Eyes……………..__NO__YES

Itching…………………………..__NO__YES
Burning…………………………__NO__YES
Foreign Body Sensation………__NO__YES
Excess Tearing/Watering……..__NO__YES
Glare/Light Sensitivity…………__NO__YES
Eye Pain or Soreness…………__NO__YES
Chronic Infection of Eye or Lid…__NO__YES
Styes or Chalazion……………..__NO__YES
Flashes or Floaters in Vision….. __NO__YES…
Eye surgery…__NO__YES _____________

ENDOCRINE

Thyroid/Other Glands…..__NO__YES

EARS,NOSE,MOUTH,THROAT

Allergies/Hay Fever……__NO__YES
Running Nose…………..__NO__YES
Chronic Cough…………__NO__YES

Sinus Congestion………………__NO__YES
Post-Nasal Drip…………………__NO__YES
Dry Throat/ Mouth……………...__NO__YES

RESPIRATORY

Asthma…………__NO__YES Chronic Bronchitis …….__NO__YES Emphysema……. __NO__ YES

VASCULVAR / CARDIOVASCULAR

Diabetes……………………__NO __YES………….Heart Pain…………….__NO __YES
High Blood Pressure………__NO __YES………….Vascular Disease……__NO __YES

GASTROINTESTINAL

Diarrhea……………………..__NO __YES Constipation……………__NO __YES

GENITOURINARY

Genitals/ Kidney / Bladder…__NO __YES

BONES/ JOINTS/ MUSCLES

Rheumatoid Arthritis…………__NO __YES Muscle Pain…..__NO __YES Joint Pain……__NO __YES

LYMPHATIC / IMMUNOLOGIC…….__NO __YES PSYCHIATRIC……__NO __YES

See sheet for details: There is a $ 20.00 fee for these procedures which insurance does not cover.

***RETINAL PHOTOGRAPHY…__NO I do not want this done today. __YES I do want this done today**
***PUPIL DILATION…__NO I do not want my eyes dilated today __YES I do want my eyes dilated today**

I ACKNOWLEDGE THAT A COPY OF DR. EPSTEIN & ASSOCIATES PRIVACY NOTICE HAS BEEN MADE AVAILABLE TO ME.

***SIGNATURE ON FILE**____**DATE**_________