Name:
DOB:
Chart:
Age:
Date:

THAMES EYE GROUP, P.C.
PATIENT HISTORY RECORD

NAME: _____ DATE: _____

DAT OF BIRTH: _____ AGE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

OCCUPATION: _____

HAVE YOU EVER HAD ANY EYE DISEASE OR EYE SURGERY? (GLAUCOMA, CATARACTS OR CATARACT SURGERY, RETINAL DETACHMENT, LASIK, ETC) _____

FAMILY HISTORY OF EYE DISEASE? ☐ Y ☐ N _____ WHO? _____

DO YOU WEAR CONTACTS? ☐ Y ☐ N ARE YOU PREGNANT? ☐ Y ☐ N

ARE YOU ON ANTICOAGULANT? ☐ Y ☐ N COUMADIN WARFARIN PLAVIX
ASPIRIN 81 MG ASPIRIN 325 MG

REVIEW OF SYSTEMS: HAVE YOU HAD ANY OF THESE PROBLEMS?

CARDIOVASCULAR ☐Y ☐ N ☐ HYPERTENSION ☐ HISTORY OF HEART ATTACK
☐ CORONARY ARTERY DISEASE ☐ CHF
☐ DEFIBRILLATOR ☐ PACEMAKER
☐ HEART SURGERY _____
☐ ARRHYTHMIA _____
☐ HIGH CHOLESTEROL _____
☐ OTHER _____

RESPIRATORY ☐ Y ☐ N ☐ SLEEP APNEA ☐ ASTHMA ☐ COPD
☐ OTHER _____

NEUROLOGICAL ☐ Y ☐ N ☐SEIZURE DISORDER ☐ DEMENTIA ☐ HEADACHES
☐ALZHEIMER'S ☐ HISTORY OF STROKE ☐ MS
☐OTHER _____

ENDOCRINE ☐ Y ☐ N ☐DIABETES ☐ HYPOTHYROIDISM/HYPERTHYROIDISM
☐OTHER _____

GASTROINTESTINAL ☐ Y ☐ N ☐ACID REFLUX _____
☐OTHER _____

MUSCULOSKELETAL ☐ Y ☐ N ☐ARTHRITIS ☐ WEAKNESS
☐OTHER _____

PROSTATE/KIDNEYS ☐ Y ☐ N ☐OTHER _____

HISTORY OF MRSA ☐ Y ☐ N

LATEX ALLERGY ☐ Y ☐ N

ADDITIONAL SIGNIFICANT MEDICAL CONDITIONS _____

PREVIOUS SURGERIES _____