Please Complete History Form

Susskind & Almallah Eye Associates

Name: Date

1 Please describe any concern or problems you have with your eyes:

2 Do you wear : ☐ glasses? ☐contact lens?

3 Date of last eye exam? and Doctor?
Date:_____Doctor:_____

4 Please check any of the problems you have with your vision or sight.

- ☐ disturbance in clarity
- ☐ blurred
- ☐ decrease in night vision
- ☐ glare or streaks around lights
- ☐ halos around lights
- ☐ sees flashes of light
- ☐ spots before your eyes
- ☐ trouble identifying colors
- ☐ double vision

Other_____

5 Please list any of the problems you have with your eyes.

- ☐ red or bloodshot
- ☐ itching or burning sensation
- ☐ eyes water a lot
- ☐ discharge or pus
- ☐ sensitive to light
- ☐ gritty sensation
- ☐ other (please name)

6 Please check or describe problems with your eyelids.

- ☐ eyelids itch or burn
- ☐ stick together in the morning
- ☐ red and swollen eyelids
- ☐ other (please describe)

7 Have you ever had eye surgery?
☐ Yes ☐ No If yes, please describe

8 Have you had any eye injury?
☐ Yes ☐ No If yes, please describe

9 List all medication you are currently taking, including eye drops, birth control pills, and medications you buy without a prescription.

Cont:

10 Please give the following for the last three times you have been hospitalized. (except normal pregnancies)

Reason for hospitalization Month/Yr.

11 List anything you are allergic to, including medicines.

12 Review of Systems

No	Yes	Comments
☐	☐	Neurological _____
☐	☐	Head Trauma_____
☐	☐	Ears, Nose, Throat_____
☐	☐	Respiratory_____
☐	☐	Cardiovascular_____
☐	☐	Hypertension_____
☐	☐	Gastrointestinal_____
☐	☐	Genituourinary_____
☐	☐	Hematologic/Lymph_____
☐	☐	Endocrine_____
☐	☐	Diabetes_____
☐	☐	Musculoskeletal_____
☐	☐	Skin_____
☐	☐	Cancer_____
☐	☐	Infectious Disease_____
☐	☐	Immunologic/Allergic_____
☐	☐	Psychiatric_____

13 Please indicate if you or any blood Relatives have had any of the following conditions.

You	Relative	
☐		AIDS
☐	☐	lupus/collagen dis.
☐		hepatitis
☐		emphysema/asthma
☐	☐	diabetes or 'sugar'
☐		high blood press.
☐		heart condition
☐		thyroid or arthritis
☐	☐	cancer or tumor
☐	☐	blindness
☐	☐	glaucoma
☐	☐	retinal detachment
☐		cigarette smoker

Doctors Signature_____