Omaha Center for Sight
Patient History

Patient Name: ________________________ Date of Birth: _________________________ Date: ___________
Primary Care Doctor: ______________________________ Additional doctor(s): _______________________________
Preferred Pharmacy: ______________________________ Location: _________________________________________
What is the primary reason for your appointment today? _____________________________________________________
Do you wear? ☐ Eye glasses ☐ Contact lenses Where and when was your last eye exam?___________________________

**Current or Past _eye conditions_?** ☐ None

☐ Cataracts
☐ Corneal Disease
☐ Crossed or Lazy eye
☐ Diabetic Eye Disease
☐ Dry Eyes
☐ Glaucoma
☐ Glaucoma Suspect
☐ Iritis/Uveitis
☐ Retinal Detachment
☐ Macular Degen
☐ Eye Injuries: ________________________
☐ Other eye disorders: ________________________

**Which _eye medications_ do you take?** ☐ None
(include prescription and over the counter eye medications)

| Medication | Which Eye | How often |
|---|---|---|
| ________________________ | Right Left | _____________ |
| ________________________ | Right Left | _____________ |
| ________________________ | Right Left | _____________ |
| ________________________ | Right Left | _____________ |

**Which _eye surgeries_ have you had?** ☐ None

| Type of Surgery | Which Eye | |
|---|---|---|
| ________________________ | Right Left | ______________ |
| ________________________ | Right Left | ______________ |
| ________________________ | Right Left | ______________ |
| ________________________ | Right Left | ______________ |

**Have you had any of these conditions?** ☐ None

☐ Diabetes:
If yes: Type 1 or Type 2
# of years ______, AIC ______
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Carotid Artery Disease
☐ Heart disease
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV or AIDS
☐ Lupus
☐ Migraines
☐ Multiple sclerosis
☐ Nervous disorder (ie: seizures, tremor)
☐ Psychiatric Disorder (ie: depression, bipolar)
☐ Stroke
☐ Thyroid Dysfunction
☐ Other: ________________ ________________________

(Women) Are you pregnant? ☐ No ☐ Yes

Have you had a flu vaccination? ☐ No ☐ Yes
Have you had a pneumonia vaccination? ☐ No ☐ Yes
Do you have a latex sensitivity? ☐ No ☐ Yes

**What general medical surgeries or injuries have you had?**
☐ None _____________________________________________
_____________________________________________________
_____________________________________________________

**What medications do you currently take?** ☐ None
☐ See attached list
_____________________________________________________
_____________________________________________________
_____________________________________________________

**Medication Allergies:** ☐ None Known
_____________________________________________________
_____________________________________________________

**Have any family members had?** ☐ None
**(ie: parents, grandparents, siblings, children)**

☐ Blindness
☐ Corneal Disease
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Detachment
☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ High blood Pressure
☐ Thyroid Dysfunction
☐ Other: ________________ __________________________ __________________________

**Are you a smoker or tobacco user?**
☐ No ☐ Everyday ☐ Some days
**Have you ever been a smoker or tobacco user?** ☐ Yes ☐ No

**Do you drink Alcohol?** ☐ No ☐ Occasionally/Socially
☐ 1-2 drinks daily ☐ 3-4 drinks daily ☐ 5+ drinks daily
**What is your Occupation?** _______________________________
☐ Full Time ☐ Part Time ☐ Retired