Omaha Center for Sight
Patient History

Patient Name: _____ Date of Birth: _____ Date: _____
Primary Care Doctor: _____ Additional doctor(s):_____
Preferred Pharmacy: _____

Your Past Medical History: Do you have or have you had?

- ☐ Diabetes: Type 1 or Type 2
  # of years _____ Last A1C _____
- ☐ Arthritis/Rheumatoid Arthritis
- ☐ Asthma
- ☐ Cancer (any other disease)
- ☐ Carotid Artery Disease
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Lupus
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Nervous disorder (seizures, tremor)
- ☐ Psychiatric Disorder (depression)
- ☐ Stroke
- ☐ Thyroid Dysfunction
- ☐ (Women) are you pregnant?
- ☐ Do you have a latex sensitivity?
- ☐ Medication Allergies: _____
  _____

☐ Medical surgeries or injuries (Please list all): _____
_____

☐ Current Medications: _____
_____

Your Eye History: Do you have or have you had?

- ☐ Cataracts
- ☐ Corneal Disease
- ☐ Crossed or Lazy eye
- ☐ Glaucoma
- ☐ Iritis/Uveitis
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Cataract Surgery
- ☐ LASIK or Refractive Surgery
- ☐ Eye Injuries: _____
  _____
- ☐ Other eye disorders or surgeries:
  _____
  _____

Your Family History (ie: parents, grandparents, siblings, children)

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

Social History:

Have you had a flu vaccination? ☐ Yes ☐ No
Have you had a pneumonia vaccination? ☐ Yes ☐ No
Are you a smoker or tobacco user? ☐ Yes ☐ No
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
Are you retired? ☐ Yes ☐ No, your Occupation: _____