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 ☐ Soft contact lenses ☐ Hard contact lenses ☐ None
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 medications)

Medication	Which Eye	How often
_____	Right Left	_____
_____	Right Left	_____

Which *eye surgeries* have you had? ☐ None

Type of Surgery	Which Eye
_____	Right Left _____
_____	Right Left _____

Have you had a flu vaccination? ☐ No ☐ Yes
Have you had a pneumonia vaccination? ☐ No ☐ Yes

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

What general medical surgeries or injuries have you had?
☐ None _____
_____

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

Medication Allergies: ☐ None Known
_____
_____

Do you have a latex sensitivity? ☐ No ☐ Yes

Have any family members had? ☐ None
Please specify who in the space provided:
Examples: parents, grandparents, siblings

☐ 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