

NOVUS clinic

PATIENT HISTORY FORM

Last Name _____ First Name _____ Date _____

1. What is the reason for your visit today? _____

2. Are you allergic to any medications or anesthesia? If yes, please list: _____

3. Please list any previous surgeries (including tooth extractions) or hospitalizations. Give approximate date: _____

4. Do you smoke regularly? Yes _____ No _____ Do you drink alcohol or beer regularly? Yes _____ No _____

Do you have, or have you had, any of the following disease or symptoms?	YES	NO
Diabetes		
Hypertension		
Bleeding disorders (Hemophilia)		
Heart Attack		
Stroke		
Sickle Cell Disease		
Breathing Disorders (Asthma/COPD)		
HIV		
Thyroid Problems		
Arthritis (Rheumatoid)		
Hepatitis		
Syphilis		
Tuberculosis		
Sarcoidosis/Lupus		
Cold Sores		
Weakness or Paralysis		
Fever		
Rapid Weight Loss/Gain		

Hobbies/Interest	YES	NO
Do you play golf?		
Do you play any other sports?		
Do you use the computer more than two hours a day?		

Patient Signature _____

Date _____

Doctor Signature _____

Date _____

Do you have, or have you ever had, any of the following eye disease or symptoms?	YES	NO
Eye Injury		
Eye Surgery		
Eye Inflammation (Iris, Uveitis, Conjunctivitis)		
Lazy Eye		
Glaucoma		
Cataracts		
Age-Related Macular Degeneration		
Eye Pain		
Reaction to Eye Drops		
Ever worn contact lenses		

Do you ever experience any of the following dry eye symptoms?	YES	NO
Sandy/Gritty feeling		
Redness		
Itching and Burning		
Fluctuating Vision		
Tearing		
Foreign body sensation		
Contact Lens discomfort		

Does anyone in your family have a history of:	YES	NO
Glaucoma		
Retinal detachment		
Lazy Eye		
Cataracts		
Eye Muscle Misalignment		
Macular Degeneration		
Blindness		