Central Arkansas Ophthalmology
Comprehensive Eye Care & Surgery

Patient History Form

Name:	Age:	Date:

Have you had a history of:	**Yes**	**No**		**Yes**	**No**
Double vision			Diabetes		
Decreased or blurred vision spells			High blood pressure		
Eye pain			Heart disease		
Floaters in your vision			Lung disease		
Flashing lights			Neurologic disease/stroke		
Eye injury			Thyroid disease		
Serious eye infection			Ear, nose, mouth, throat problems		
Eyelid problems					
Abnormal pupil			Eye Surgery (list)		
Cornea disease					
Glaucoma					
Cataract			Other surgery (list)		
Retinal disorder					
Eye tumor					
In or out turning of eye					
			Is there a family history of:		
			Cataracts		
Allergies to eye drops (list)			Glaucoma		
			Diabetes		
			Macular Degeneration		
Allergies to medications (list)			Blindness (any cause)		
			Lazy Eye		
			Other eye disorders		
			Cancer		
Are you experiencing fever/weight loss?			HBP		

What is (was, if retired) your occupation?	**Yes**	**No**
Do you smoke now?		
Have you smoked for 1 year or more?		
Do you drink alcohol daily?		
Have you had a flu shot vaccination in the last year?		
Are you concerned that you occupation adversely affects your eyes?		
Are you HIV Positive?		
Do you drive?		
Do you have problems with night vision?		
Comments (Regarding YES Answers)		

History Review: ☐ No Changes ☐ Additions as Noted

Patient's Signature: _____ Date: _____