Thame Eye Group, P.C.
Patient History Record

Name: ____ Date: ______________________________________
Date of Birth: ____ Age: ______________________________________
Primary Care Physician: ________________________________ Referred by: _______________________________
Occupation: ____

Have you ever had any eye disease or eye surgery? (Glaucoma, Cataracts or Cataract Surgery, Retinal Detachment, Lasik, etc.) ____
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Family history of eye disease? ( ) Yes ( ) No What?________________________ Who?______________________
Do you wear contacts? ( ) Yes ( ) No
Are you pregnant? ( ) Yes ( ) No
Do you use a wheelchair? ( ) Yes ( ) No
Are you on an anticoagulant? ( ) Yes ( ) No Coumadin / Warfarin / Plavix / Eliquis
Aspirin 81mg / Aspirin 325mg / Pradaxa / Xarelto

Review of Systems: Have you had any of these problems?

Cardiovascular ( ) Yes ( ) No
( ) Hypertension ( ) History of a Heart Attack
( ) CHF ( ) Coronary Artery Disease
( ) Defibrillator ( ) Pacemaker
( ) Heart Murmur
( ) Heart Surgery ____
( ) Arrhythmia ____
( ) High Cholesterol ____
( ) Other ____

Respiratory ( ) Yes ( ) No
( ) Sleep Apnea ( ) COPD
( ) Oxygen Full Time ( ) Asthma
( ) Oxygen Part Time ( ) Other ____________________________

Neurological ( ) Yes ( ) No
( ) Seizure Disorder ( )Dementia
( ) Headaches ( ) Alzheimer's
( ) History of Stroke ( ) MS
( ) Parkinson's ( ) Panic/Anxiety Attacks
( ) Depression ( ) Other ____________________________

Endocrine ( ) Yes ( ) No
( ) Diabetes ( ) Hypothyroidism/Hyperthyroidism
( ) Insulin ( ) Other ____________________________

Gastrointestinal ( ) Yes ( ) No
( ) Acid Reflux ( ) Other ____________________________

Musculoskeletal ( ) Yes ( ) No
( ) Arthritis ( ) Chronic Pain Syndrome
( ) Weakness ( ) Other ____________________________

Prostate/Kidneys ( ) Yes ( ) No
( ) Prostate Problems ( ) Dialysis

History of MRSA ( ) Yes ( ) No
Latex Allergy ( ) Yes ( ) No

Additional significant medical conditions ____
Previous Surgeries ____
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