

## PREMIER EYE CARE & SURGERY, P.C.

Jason M. Jacobs, M.D.

### Patient History Form

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Referred By \_\_\_\_\_

#### REVIEW OF SYSTEMS

*Do you currently have any of the following problems?*

If yes, please explain

<b>1. Please list medications you are taking, including eye drops.</b>	1. 2. 3. 4. 5. 6. 7. 8.	
<b>2. Do you have any allergies to any medication?</b>	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>3. Have you recently had any chronic fever, unexpected weight loss/gain, or fatigue?</b>	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>4. Eyes</b> (glaucoma, cataract, lazy eye, retina problems, other)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>5. Ear / nose / mouth / throat</b> (hearing loss, sinus problems, sore throat)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>6. Cardiovascular</b> (heart problems, chest pain, irregular heart beat)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>7. Respiratory</b> (asthma, shortness of breath, wheezing, coughing)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>8. Gastrointestinal</b> (heartburn, abdominal pain, diarrhea, vomiting)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>9. Genitourinary</b> (urinary problems, blood in urine)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>10. Integumentary</b> (skin rashes, excessive dryness)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>11. Musculoskeletal</b> (muscle aches, joint pain, swollen joints)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>12. Neurological</b> (numbness, weakness, headaches, paralysis)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>13. Hematologic / Lymphatic</b> (blood disorders, leukemia)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>14. Allergic / Immunologic</b> (hay fever, allergies)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>15. Endocrine</b> (thyroid problems, diabetes)	yes    no <input type="checkbox"/> <input type="checkbox"/>	
<b>16. Psychiatric</b> (depression, anxiety)	yes    no <input type="checkbox"/> <input type="checkbox"/>	

**Family and social history:** Do any medical or eye diseases run in your family? If YES, please note the relationship to you.

- Glaucoma \_\_\_\_\_
- Diabetes \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Macular degeneration \_\_\_\_\_
- Other \_\_\_\_\_

Do you smoke? If YES, how much?

Drink alcohol? If YES, how much?

Comments: \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_