James S. Linder, MD, PC
PATIENT HISTORY FORM

Name_____ Date of Birth_____

1. Are you currently being treated for any eye, eyelid, tear duct, or orbit problem? Please describe._____

2. Are you being treated for any medical condition? Please circle all that apply:

Diabetes	Heart Disease	High Blood Pressure
Stroke	Cancer (including skin cancer)	Thyroid Disease
	Sleep Apnea	COPD/Emphysema

3. Have you had ANY surgery in the past? Please list approx. date and type of operation. Please include any eye, eyelid, tear duct, or orbit surgeries.
_____

4. Is there any family history of eye problems (examples: glaucoma, retinal degeneration, crossed eyes, droopy lids, etc.)? Please describe._____
_____

5. Please list all prescription and over the counter medications you are taking. Please include eye medications. (Attach list if preferred) _____
_____

6. Please list ANY drug you are ALLERGIC to and describe the reaction.
_____

7. Do you drink? If so, how much? _____
Do you smoke or use any tobacco products? If so, how much? _____
Are you a former smoker? _____

8. Is your Influenza immunization current? _____ When? _____
Is your Pneumococcal immunization current? _____ When? _____

Patient signature _____Date_____

Reviewed by/MD signature_____

Patient Name_____
Date of Birth_____

PATIENT HISTORY –cont.

Do you currently have any of the following symptoms? Please circle.

Unexplained weight loss, fatigue, or weakness	Yes	No_____
Skin Rashes or sores	Yes	No_____
Headaches	Yes	No_____
Hearing loss or ringing in the ears	Yes	No_____
Sinus troubles or nosebleeds	Yes	No_____
Chest pain	Yes	No_____
Shortness of breath or persistent cough	Yes	No_____
Heartburn, stomach aches, or vomiting blood	Yes	No_____
Diarrhea or blood in stools	Yes	No_____
Pain on urination or blood in urine	Yes	No_____
Muscle aches, joint pain, swollen joints	Yes	No_____
Numbness/tingling or loss of function	Yes	No_____
Dizziness, fainting, or blackouts	Yes	No_____
Memory loss or confusion	Yes	No_____
Depression or mood changes	Yes	No_____
Excessive urination or thirst	Yes	No_____
Bruising, bleeding, or anemia	Yes	No_____

Other_____

_____

COMMENTS: _____

_____

Patient signature _____Date_____

Reviewed by/MD signature_____