PRAIRIE
Eye Center, LTD

Patient History Form **Date: _____/_____/20____**

Patient Name:	Allergies:
DOB:	
Eye Doctor (Optometrist)	Eye Drops / Vitamins
Referred by:	
Primary Care Physician:	**Pharmacy / Location:**
Past Eye Surgery:	
	Current medications: (List attached Yes No Circle one)
Other Surgery (Type/Date):	
MEDICAL HISTORY	
Have you had MRSA or an antibiotic resistant infection? Yes No (Circle One)	
Are you Hepatitis __ positive? Yes No (Circle One)	Have you **ever** or are you **currently** taking **Flomax**?
Are you HIV positive? Yes No (Circle One)	(For prostate or urinary problems) Yes No (Circle One)

Personal History Do you or have you had?	**Yes**	**Year Diagnosed**	**No**
Diabetes If yes, type?			
High Blood Pressure			
High Cholesterol			
Stroke			
Heart Attack / Failure			
Stomach Ulcers			
Cancer / Tumor			
Sickle Cell			
Emphysema			
Asthma / COPD			
Hepatitis			
Thyroid disease			
Rheumatoid Arthritis			
Lupus			
Migraines			
Lazy Eye			
Eye Infection			
Eye Injury			
Blindness			
Glaucoma			
Cataracts			
Macular Degeneration			
Depression / Anxiety			
Do you wear glasses?			
Do you wear contacts?			

Family History (Please list relation)	**YES**	**NO**
Glaucoma		
Macular Degeneration		
Retinal Detachment		
Cataracts		
Lazy Eye		
Diabetes		
High Blood Pressure		
Social History	**YES**	**NO**
Do you smoke? If yes, how long?		
If yes, how many a day?		
Do you consume alcohol?		
If yes, how much?		
Do you smoke / consume marijuana (THC)?		
If yes, how much?		
Have you had a Pneumonia vaccine?		
If yes when		
Have you had a Covid vaccine?		
If yes when		
Any other information your doctor should know:		