KAMEEN
EYE ASSOCIATES

# PATIENT HISTORY RECORD

Date: ____________________

Acct # ____________________

Patient Name ________________________________________ ☐ Male ☐ Female Referred by ____________________
Last First Middle Initial

Birth Date ____________________ Age __________ SS# ________________________

Address ________________________________________________________________
Street City State Zip

Home Phone ________________ Work/Cell Phone ________________ Email Address ________________

Employer ________________________________________ Occupation ________________________

Health Insurance Carrier ____________________________ Vision Insurance ________________________

Current Eye Doctor ______________________ Last Seen ______ Primary Care Physican ____________________

## OCULAR INFORMATION

Past Ocular History ☐ None

☐ Cataracts ☐ Glaucoma ☐ Retinal tear/detachment
☐ Recurrent Corneal Erosions ☐ Herpes Simplex/Zoster ☐ Keratoconus
☐ Amblyopia/Lazy eye ☐ Double Vision ☐ Trauma/Scar
☐ Dry Eyes ☐ Punctual Plugs ☐ Corneal Abrasion

Comments ________________________________________________________________

Past Ocular Surgery ☐ None

☐ Muscle ☐ Retinal ☐ PRK/LASIK/CK
☐ RK ☐ Corneal Transplant ☐ Cataract

Comments ________________________________________________________________

Current Lens History ☐ None

☐ Soft Daily ☐ Soft Extended (Overnight wear ☐Yes ☐No)
☐ Soft Toric ☐ RGP (Gas Permeable Lenses) ☐PMMA (Hard Lenses)

Number of Years worn __________ Lenses last worn ______________

Difficulty with CL wear ☐Yes ☐No If Yes, explain ________________________________

Family Ocular History ☐ None

☐ Retinal Detachment ☐ Glaucoma

Comments ________________________________________________________________

## MEDICAL HISTORY

General Health Problems ☐ None

☐ Pregnant/Nursing ☐ Smoker; how long______ ☐ Diabetes
☐ Rheumatoid Arthritis ☐ Autoimmune Disorder ☐ Claustrophobia
☐ High Blood Pressure ☐ Healing problems/keloids ☐ Skin Conditions (Rosacea/Eczema)
☐ HIV ☐ Pacemaker
☐ Back or Neck problems (difficulty lying on your back)
☐ Other; List ________________________________________________

Medications ☐ None ☐ Yes; list ________________________________________

Medication Allergies ☐ None ☐ Yes; list ________________________________________

SIGNATURE ________________________________________________________________

Any health changes require a new Patient History Record Form to be fillled out.