Name:______________________________ **Date:**_____________

Reason for your visit today:____

Do you have any of the following eye problems?

Difficulty reading:	☐Y	☐N	Eye Pain:	☐Y	☐N	Glaucoma:	☐Y	☐N
Difficulty driving:	☐Y	☐N	Dry Eye:	☐Y	☐N	Cataract:	☐Y	☐N
Glare:	☐Y	☐N	Eye Redness:	☐Y	☐N	Diabetic Eye Disease:	☐Y	☐N
Flashing lights:	☐Y	☐N	Eye Discharge:	☐Y	☐N	Macular Degeneration:	☐Y	☐N
Floaters:	☐Y	☐N	Tearing:	☐Y	☐N	Retinal Detachment:	☐Y	☐N
Double Vision:	☐Y	☐N	Itchy Eye:	☐Y	☐N	Trauma to Eye:	☐Y	☐N
Vision Loss:	☐Y	☐N	Swollen Lids:	☐Y	☐N	Lazy Eye:	☐Y	☐N

Other: ____

Allergies:____

Do you wear glasses? ☐ Yes ☐ No How old are they?__________ ☐ *Single* ☐ *Multifocal* ☐ *Readers*
Do you wear Contact Lenses? ☐ Yes ☐ No ☐ Hard ☐ Soft ☐ Multifocal
Right Eye: Brand:__________________ Power:________ BC:_________ Diameter:________
Left Eye: Brand:__________________ Power:________ BC:_________ Diameter:________

Have you ever had eye surgery or laser surgery?

Cataract Surgery:	☐Y	☐N	LASIK/PRK:	☐Y	☐N
Glaucoma Surgery:	☐Y	☐N	Laser for Glaucoma:	☐Y	☐N
Eye Muscle Surgery:	☐Y	☐N	Laser for Diabetes:	☐Y	☐N
Retinal Detachment Surgery:	☐Y	☐N	Macular Degeneration Treatment:	☐Y	☐N
Eye Lid Surgery:	☐Y	☐N	Other___________________________________		

Past Medical History:

Arthritis	☐Y	☐N	High Blood Pressure	☐Y	☐N
Cancer	☐Y	☐N	Breathing Problems	☐Y	☐N
Cholesterol	☐Y	☐N	Auto immune Disease	☐Y	☐N
Diabetes *Type I or II*	☐Y	☐N	Thyroid Problems	☐Y	☐N
Heart Problems	☐Y	☐N	Seasonal Allegies	☐Y	☐N

Others____

Previous Surgeries *(type & date)*:____

Eye Medications

Name	L or R eye	How often
1)		
2)		
3)		
4)		
5)		

Oral Medications

1)	7)
2)	8)
3)	9)
4)	10)
5)	11)
6)	12)

Family History: *Check*

☐ Diabetes	☐ Stroke	☐ Blindness	☐ Macular Degeneration	☐ Arthritis
☐ Cancer	☐ TB	☐ Cataracts	☐ Retinal Disease	☐ Lazy Eye
☐ Heart Disease	☐ Kidney Disease	☐ Glaucoma	☐ High Blood Pressure	☐ Other/Explain:

Social History: *Circle*

Smoking: ☐ **No,** Never Smoked or ☐ Former smoker
☐ **Yes**: Daily or Some Days **Frequency:** Social, ½ pack, 1 pack, >1 pack

Alcohol: ☐ **No** or ☐ **Yes:** Daily Socially On Occasion **How Much?** 1 glass, 2 glasses, >3 glasses Per day

Drug: ☐ No ☐ Yes, **Drug Used:** ______________________________ **Frequency:** ____________________

Review of Systems: Please Check

Patient Name: ____________________

Eyes

Previous Surgery Y N
Contact Lens ☐ Y ☐ N
Pain ☐ Y ☐ N
Double Vision ☐ Y ☐ N
Glaucoma ☐ Y ☐ N
Cataracts ☐ Y ☐ N
Macular Degeneration ☐ Y ☐ N
Dry Eyes ☐ Y ☐ N
Flashes ☐ Y ☐ N
Floaters ☐ Y ☐ N

Ear, Nose and Throat

Hard of Hearing ☐ Y ☐ N
Ringing in Ears ☐ Y ☐ N
Vertigo ☐ Y ☐ N

Cardiovascular

Chest Pain ☐ Y ☐ N
Dizziness ☐ Y ☐ N
Fainting Spells ☐ Y ☐ N
Shortness of Breath ☐ Y ☐ N
Irregular Heart Beat ☐ Y ☐ N
Difficulty Lying Flat ☐ Y ☐ N

Constitutional

Fatigue/Weakness ☐ Y ☐ N
Fever ☐ Y ☐ N
Weight Gain/Loss ☐ Y ☐ N

Respiratory

Cough ☐ Y ☐ N
Congestion ☐ Y ☐ N
Wheezing ☐ Y ☐ N
Asthma ☐ Y ☐ N

Gastrointestinal

Heartburn ☐ Y ☐ N
Nausea/Vomiting ☐ Y ☐ N
Jaundice/Hepatitis ☐ Y ☐ N

Genito-Urinary

Pain/Difficulty ☐ Y ☐ N
Blood in Urine ☐ Y ☐ N
Hist of Kidney Stones ☐ Y ☐ N
History of STDs ☐ Y ☐ N

Psychiatric

Anxiety/Depression ☐ Y ☐ N
Mood Swings ☐ Y ☐ N
Difficulty Sleeping ☐ Y ☐ N

Endocrine

Increased Thirst ☐ Y ☐ N
Increased Hunger ☐ Y ☐ N
Increased Urination ☐ Y ☐ N
Increased Sweating ☐ Y ☐ N
Fingernail Changes ☐ Y ☐ N

Blood/Lymphnodes

Easy Bruising ☐ Y ☐ N
Gums Bleed Easily ☐ Y ☐ N
Prolonged Bleeding ☐ Y ☐ N
Heavy Aspirin Use ☐ Y ☐ N

Musculoskeletal

Stiffness ☐ Y ☐ N
Arthritis ☐ Y ☐ N
Joint Pain/Swelling ☐ Y ☐ N

Skin

Rash/Sores ☐ Y ☐ N
Lesions ☐ Y ☐ N
Hives/Eczema ☐ Y ☐ N

Neurological

Seizures ☐ Y ☐ N
Weakness/Paralysis ☐ Y ☐ N
Numbness ☐ Y ☐ N
Tremors ☐ Y ☐ N

Immunologic

Hives ☐ Y ☐ N
Itching ☐ Y ☐ N
Runny Nose ☐ Y ☐ N
Sinus Pressure ☐ Y ☐ N