

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Last Eye Exam: \_\_\_\_\_

## Past Medical History

Please check all that apply and provide dates of onset/diagnosis:

None Recent

Medical Problems	Date of onset/diagnosis	Medical Problems (cont.)	Date
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Type 1 or <input type="checkbox"/> Type 2		<input type="checkbox"/> Cancer _____	_____
<input type="checkbox"/> Do you use insulin? <input type="checkbox"/> YES or <input type="checkbox"/> NO		<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Last A1C _____% Date tested _____			
<input type="checkbox"/> High blood pressure	_____	<b>Surgeries (other than eye)</b>	<b>Date</b>
<input type="checkbox"/> High cholesterol	_____	1. _____	_____
<input type="checkbox"/> Heart Disease	_____	2. _____	_____
<input type="checkbox"/> Stroke	_____	3. _____	_____
<input type="checkbox"/> Autoimmune disease	_____	4. _____	_____
Have you had the Influenza immunization? <input type="checkbox"/> YES <input type="checkbox"/> NO		5. _____	_____
Pneumonia vaccine? <input type="checkbox"/> YES <input type="checkbox"/> NO			

## Drug Allergies

Do you have any allergies to any medications?  YES  NO Are you allergic to latex?  YES  NO  
 Are you allergic to anesthetics?  YES  NO Are you allergic to Iodine?  YES  NO

If YES, list the medication and the reaction:

Medication	Reaction
_____	_____
_____	_____
_____	_____

## Medications

Please list all medications you currently take including over the counter drugs and/or supplements.

If you have a list of medications with you, we will gladly make a copy.

Name of Medication	Dosage	Frequency	Date Started

**Pharmacy Name:** \_\_\_\_\_

**Pharmacy Location:** \_\_\_\_\_

## Family History

**Please check all that apply and specify relation:**  Adopted/Unknown  No significant family history  
 \*\*Relation (father, mother, sister, brother, son, and/or daughter ONLY)\*\*

- |                                                     |                                               |
|-----------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Blindness _____            | <input type="checkbox"/> Heart Problems _____ |
| <input type="checkbox"/> Retinal Detachment _____   | <input type="checkbox"/> Arthritis _____      |
| <input type="checkbox"/> Macular Degeneration _____ | <input type="checkbox"/> Lupus _____          |
| <input type="checkbox"/> Glaucoma _____             | <input type="checkbox"/> Cancer _____         |
| <input type="checkbox"/> Cataracts _____            | <input type="checkbox"/> Thyroid _____        |
| <input type="checkbox"/> Diabetes _____             | <input type="checkbox"/> Stroke _____         |
| <input type="checkbox"/> Hypertension _____         | <input type="checkbox"/> Other _____          |

## Social History

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

- Do you currently smoke?  YES  NO If Yes, how much and how many years? \_\_\_\_\_  
 Did you previously smoke?  YES  NO Quit date? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_  
 Do you drink alcohol?  YES  NO If Yes, how much? \_\_\_\_\_  
 Do you use illicit drugs?  YES  NO If Yes, what substance? \_\_\_\_\_  
 Do you drive?  YES  NO

## Ocular History

Ocular History	Date of onset/diagnosis	Ocular History & Date of onset(cont.)
<input type="checkbox"/> Amblyopia (Lazy eye)	_____	<input type="checkbox"/> Cataract _____
<input type="checkbox"/> Strabismus (eye turn)	_____	<input type="checkbox"/> High eye pressure (glaucoma) _____
<input type="checkbox"/> Droopy eyelid	_____	<input type="checkbox"/> Retinal tear _____
<input type="checkbox"/> Infection	_____	<input type="checkbox"/> Retinal detachment _____
<input type="checkbox"/> Trauma	_____	<input type="checkbox"/> Nevus (freckle) _____
<input type="checkbox"/> Dry eye	_____	<input type="checkbox"/> Other: _____

Eye Surgeries	Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

- Please list all eye drops you use:**
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_

## Review of Systems

Do you currently have any symptoms or conditions in the following areas,  
even if controlled by medication?

	<b>NO</b>	<b>If YES, check all that apply.</b>
<b>GENERAL</b>		<input type="checkbox"/> weight loss <input type="checkbox"/> fever <input type="checkbox"/> fatigue <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> weight gain <input type="checkbox"/> headaches <input type="checkbox"/> other:
<b>EARS, NOSE, THROAT</b>		<input type="checkbox"/> ringing in the ears (tinnitus) <input type="checkbox"/> hard of hearing <input type="checkbox"/> ear pain <input type="checkbox"/> sinus disease <input type="checkbox"/> nose bleeds <input type="checkbox"/> ear infection <input type="checkbox"/> cold sores <input type="checkbox"/> mouth sores <input type="checkbox"/> sore throat <input type="checkbox"/> TMJ pain <input type="checkbox"/> other:
<b>CARDIOVASCULAR</b>		<input type="checkbox"/> heart attack <input type="checkbox"/> chest pain (angina) <input type="checkbox"/> heart murmur <input type="checkbox"/> palpitations <input type="checkbox"/> edema <input type="checkbox"/> high blood pressure <input type="checkbox"/> shortness of breath <input type="checkbox"/> other:
<b>RESPIRATORY</b>		<input type="checkbox"/> cough <input type="checkbox"/> asthma <input type="checkbox"/> bloody sputum <input type="checkbox"/> COPD <input type="checkbox"/> other:
<b>GASTROINTESTINAL</b>		<input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> heartburn <input type="checkbox"/> acid reflux <input type="checkbox"/> change in appetite <input type="checkbox"/> abdominal pain <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> bloody stools <input type="checkbox"/> other:
<b>GENITOURINARY</b>		<input type="checkbox"/> kidney stone <input type="checkbox"/> kidney disease <input type="checkbox"/> UTI <input type="checkbox"/> blood in urine <input type="checkbox"/> painful urination <input type="checkbox"/> other:
<b>MUSCULOSKELETAL</b>		<input type="checkbox"/> joint pain <input type="checkbox"/> joint stiffness <input type="checkbox"/> muscle pain <input type="checkbox"/> muscle cramps <input type="checkbox"/> muscle weakness <input type="checkbox"/> other:
<b>DERMATOLOGIC</b>		<input type="checkbox"/> breast lumps <input type="checkbox"/> changes in moles <input type="checkbox"/> changes in hair <input type="checkbox"/> changes in nails <input type="checkbox"/> varicose veins <input type="checkbox"/> psoriasis <input type="checkbox"/> eczema <input type="checkbox"/> skin cancer <input type="checkbox"/> other:
<b>PSYCHIATRIC</b>		<input type="checkbox"/> depression <input type="checkbox"/> mania <input type="checkbox"/> suicidal tendencies <input type="checkbox"/> anxiety <input type="checkbox"/> memory loss <input type="checkbox"/> dementia <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> other:
<b>NEUROLOGICAL</b>		<input type="checkbox"/> seizures <input type="checkbox"/> tremors <input type="checkbox"/> vertigo <input type="checkbox"/> numbness <input type="checkbox"/> tingling <input type="checkbox"/> speech problems <input type="checkbox"/> other:
<b>ENDOCRINE</b>		<input type="checkbox"/> hyperthyroid <input type="checkbox"/> hypothyroid <input type="checkbox"/> type 1 diabetes <input type="checkbox"/> type 2 diabetes <input type="checkbox"/> other:
<b>HEMATOLOGICAL</b>		<input type="checkbox"/> anemia <input type="checkbox"/> easy bruising <input type="checkbox"/> elevated cholesterol <input type="checkbox"/> other:
<b>IMMUNOLOGICAL</b>		<input type="checkbox"/> connective tissue disease <input type="checkbox"/> lupus <input type="checkbox"/> seasonal allergies <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> other:

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_