NAME ______________________ **DOB** __________ **DATE** __________

Primary Doctor ______________________ **Pharmacy** ______________________

Do you wear glasses, bifocals or contact lenses? ______________________

Eyes: *With your glasses or contacts (or without, if you do not wear), do you have any difficulty . . .*

YES	NO		YES	NO	
☐	☐	Reading small print (medicine bottles, newspaper, etc.)	☐	☐	Headache
☐	☐	Reading traffic or street signs	☐	☐	Gritty, Sandy eyes
☐	☐	Handy work such as sewing, knitting, carpentry, etc.	☐	☐	Droopy eyelids
☐	☐	Writing checks or filling out forms	☐	☐	Tiredness of eyes
☐	☐	Driving during the day or with night vision	☐	☐	Twitching or shaking eye of eyelids
☐	☐	Double vision	☐	☐	Crossed, turned, or wandering eye
☐	☐	Blurry vision uncorrectable by lenses	☐	☐	Flashes or streaks of light
☐	☐	Dimming of vision that comes and goes	☐	☐	New floaters (spots, strings, or shadows)
☐	☐	Sudden loss of vision	☐	☐	Discharge, crusting, or excessive tearing
☐	☐	Red or pink eye	☐	☐	Swelling of the eye or eyelid
☐	☐	Eye pain	☐	☐	Bulging of one or both eyes
☐	☐	Loss of side vision	☐	☐	Difference in the size of the eyes or pupils
☐	☐	Haloes (colored rays or circles around lights)	☐	☐	Light sensitivity
☐	☐	Dry eye symptoms(burning pain)			Other ______________________

Medical History

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Kidney Disease	☐	☐	Hepatitis	☐	☐	AIDS
☐	☐	Epilepsy	☐	☐	Peptic Ulcer	☐	☐	Graves Disease	☐	☐	Lupus
☐	☐	Sjorgens	☐	☐	Diabetes	☐	☐	Stroke	☐	☐	TIA
☐	☐	GERD	☐	☐	Migraines	☐	☐	Temporal Arteritis	☐	☐	Gout
☐	☐	Arthritis	☐	☐	MS	☐	☐	High Blood Pressure	☐	☐	Leukemia
☐	☐	Heart Disease	☐	☐	Pacemaker	☐	☐	Shingles			Other __________

List all **Surgeries** and approximate dates: ______________________

____

____

____

If you are **Diabetic,** what is your most recent **blood sugar?** __________ **HbA1C** __________ date diagnosed __________

List all prescription and non-prescription **Medications** including eyedrops ______________________

____

____

____

Medication Allergies: ☐ YES ☐ NO **If yes, please list** ______________________

Are you taking **Coumadin, Plaquenil** or **Flomax?** ☐ YES ☐ NO ______________________

PERSONAL EYE HISTORY

YES	NO	
☐	☐	Cataract
☐	☐	Glaucoma
☐	☐	Macular Degeneration
☐	☐	Retinal detatchment
☐	☐	Amblyopia(lazy eye)
☐	☐	Blind Eye
☐	☐	Night Blindness

FAMILY HISTORY

YES	NO		Relation
☐	☐	Heart Problems	__________
☐	☐	Arthritis	__________
☐	☐	Cancer(type)	__________
☐	☐	High Blood Pressure	__________
☐	☐	Lupus	__________
☐	☐	Thyroid Disease	__________
☐	☐	Diabetes	__________

REVIEW OF SYSTEMS: *Do you currently have any problems in the following areas? If yes, please explain.*

Constitutional Symptoms:

YES	NO			YES	NO	
☐	☐	Fever	______	☐	☐	Other ______
☐	☐	Weight Loss	______			

Ears, Nose, Mouth and Throat:

YES	NO			YES	NO		
☐	☐	Teething/Dentition	______	☐	☐	Sinus Congestion	______
☐	☐	Vertigo/Dizziness	______	☐	☐	post-nasal drip	______
☐	☐	Dry throat/mouth	______				

Endocrine(thyroid/diabetic)

YES	NO			YES	NO		
☐	☐	Thyroid	______	☐	☐	Diabetic	______

Allergic/Immunologic

YES	NO		
☐	☐	Seasonal Allergies/Hay fever symptoms	______
☐	☐	Immune Disorders	______

Cardiovascular

YES	NO			YES	NO		
☐	☐	Chest pain	______	☐	☐	Irregular heart rhythm or pulse	
☐	☐	Shortness of breath	______	☐	☐	Cardiac Stent placed	______

Respiratory

YES	NO			YES	NO		
☐	☐	Chronic Bronchitis	______	☐	☐	Emphysema	______
☐	☐	Asthma	______	☐	☐	Cough	______

Gastrointestinal(stomach/intestines)

YES	NO			YES	NO		
☐	☐	Ulcers	______	☐	☐	Chronic Diarrhea	______
☐	☐	Constipation	______	☐	☐	Blood in stool	______

Genitourinary (genitals/kidney/bladder)

YES	NO		YES	NO	
☐	☐	______	☐	☐	Ever taken prostate medications?

Musculoskeletal:

YES	NO			YES	NO		
☐	☐	Arthritis or aching joints	______	☐	☐	Back pain	______

Integumentary(skin and or Breast)

YES	NO		YES	NO		
			☐	☐	Rashes, sores or blisters	______
☐	☐	______	☐	☐	Unusual moles or pigmented lesions	

Neurological(nervous diseases)

YES	NO			YES	NO		
				☐	☐	Seizures	______
☐	☐	Memory loss	______	☐	☐	Depression or mood changes	

Hematologic/Lymphatic

YES	NO			YES	NO		
☐	☐	Blood disorder or anemia	______	☐	☐	Blood transfusion	______
☐	☐	Lymph nodes	______	☐	☐	Easy bleeding or bruising	______

Social History Do you drink Alcohol? ☐YES ☐NO If yes, how often? ______

Do you smoke? ☐YES ☐NO If yes, how often? ______

Signature ______ **DATE** ______