Name:_____ Preferred Name:_____

Date of Birth:_____ Family Doctor:_____

Previous Eye Doctor:_____

Are you currently or have you ever been treated for any of the following medical conditions? Please check yes or no and circle all that apply.

☐ Yes ☐ No Arthritis (rheumatoid, osteo-degenerative)
☐ Yes ☐ No Blood Disease (anemia, leukemia, clotting problems, sickle cell, elevated cholesterol)
☐ Yes ☐ No Ear, Nose, Throat (hearing loss, sinus disease)
☐ Yes ☐ No Diabetes (Type 1 or 2, how controlled and date diagnosed)
☐ Yes ☐ No Thyroid Disease (Graves, Hashimoto's, hypo, hyper)
☐ Yes ☐ No Lung Disease (asthma, emphysema, COPD, chronic bronchitis)
☐ Yes ☐ No Heart Disease (heart attack, angina, arrhythmia, heart failure, heart valve disease, bypass surgery)
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Gastrointestinal Disease (ulcers, esophageal [acid] reflux, intestinal or liver disease)
☐ Yes ☐ No Genito-Urinary Disease (kidney disease, dialysis, kidney stones
☐ Yes ☐ No Neurological problems (stroke, mini stroke, seizures, paralysis, migraines, multiple sclerosis)
☐ Yes ☐ No Skin Disease (eczema, psoriasis, acne, rosacea)
☐ Yes ☐ No Mental Health (depression, anxiety, bipolar, schizophrenia)
☐ Yes ☐ No Cancer (list type or location and date)
☐ Yes ☐ No Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis, herpes)
☐ Yes ☐ No Other (sarcoid, Raynaud's, fibromyalgia, Sjogren's, lupus, sleep apnea)

Other problems: _____

_____

Previous Surgery/Hospitalization and date: _____

Review of symptoms: Do you currently have any of the following problems? Please circle all that apply.

☐ Yes ☐ No	Joint pain (Musculoskeletal)	☐ Yes ☐ No	Sore throat, ear pain, sinus problems
☐ Yes ☐ No	Easy bruising (Hematological)	☐ Yes ☐ No	Heart burn, abdominal pain
☐ Yes ☐ No	High or low blood pressure	☐ Yes ☐ No	Pain with urination, blood in urine
☐ Yes ☐ No	High or low blood sugar	☐ Yes ☐ No	Weakness, numbness
☐ Yes ☐ No	High or low thyroid level	☐ Yes ☐ No	Rash, excessive dryness
☐ Yes ☐ No	Shortness of breath,	☐ Yes ☐ No	Depressed/anxious
	wheezing, cough, respiratory	☐ Yes ☐ No	Fever, weight loss, weight gain
☐ Yes ☐ No	Chest pain, palpitations	☐ Yes ☐ No	Dry mouth, chronic cough, allergies

Please list any medications, vitamins or supplements you take, with dosage amount (including over the counter, herbal, birth control, aspirin and eye drops)

Please list any allergies and reactions (including food, medications and environmental)

Eye Disease

Have you or anyone in your family had any of the following eye diseases?
Please specify (ex. self, mother, paternal grandfather)

☐ Yes ☐ No Cataract _____
☐ Yes ☐ No Blindness _____
☐ Yes ☐ No Corneal Disease or Transplant _____
☐ Yes ☐ No Diabetic Eye Disease _____
☐ Yes ☐ No Glaucoma _____
☐ Yes ☐ No Lazy Eye (Amblyopia) _____
☐ Yes ☐ No Macular Disorder _____
☐ Yes ☐ No Muscle Disorder (Crossed Eyes) _____
☐ Yes ☐ No Retinal Detachment or Hole _____
☐ Yes ☐ No Injury _____
☐ Yes ☐ No Surgery or Laser _____
Other/Comments: _____

Social History

Do you live alone? ☐ Yes ☐ No ☐ Assisted Living ☐ Nursing Home
Do you smoke? ☐ Yes ☐ No If yes: Occasional, ½ pack/day, 1 pack/day, 1+ pack/day
Do you drink alcohol? ☐ Yes ☐ No If yes: Occasional, 1-2/day, 3-4/day, 4+/day
What is your occupation?
If female, are you pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

What is the reason for your visit today?

Do you wear contact lenses? ☐ Yes ☐ No ☐ No, but I would like to
If yes, my most recent contact lens brand is: _____
Please enter your contact lens prescription here: Sph _____ Cyl _____ Axis _____

When was your last eye exam? _____

_____ _____
Patient Signature Date