

PATIENT INFORMATION

Single Married Divorced	First Name	Last Name	MI	Birthdate	Age	
Mailing Address		City	State	Zip	Home / Cell Phone	Work Phone
Occupation/Employer		Social Security # (Patients With Insurance Only)		Vision / Medical Insurance		

PATIENT MEDICAL / SOCIAL HISTORY

Date of last **EYE EXAM**: _____ Have your eyes been Dilated before? No Yes When? _____

Have you been examined at our office before? No Yes Do you wear contact lenses? No Yes

Do you wear glasses? No Yes If yes, For distance? For reading? For computer?

Do you use/work with a computer? No Yes, _____ hours / day.

Date of last **PHYSICAL EXAM**: _____ Name of your **PHYSICIAN**: _____

List any **MEDICATIONS** you take: _____

Are you **ALLERGIC** to any medication? No Yes If yes, list: _____

List any **EYE** diseases, injuries, or surgeries: (i.e. glaucoma, cataracts, retinal detachment, crossed eyes or macular degeneration)

Are you pregnant? No Yes Do you smoke? _____ Use alcohol? _____

What sports and hobbies do you enjoy? _____

PATIENT HISTORY - REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

	No	Yes	When?		No	Yes	When?		No	Yes	When?
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chronic Lid Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fever or weight loss	<input type="checkbox"/>	<input type="checkbox"/>	_____	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergic/Immunologi	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid/Glandular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____	c				Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased):

	No	Yes	?	Relationship to you		No	Yes	?	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Retinal Disease
Arthritis

Thyroid Disease
Other _____

