Patient Demographics & Medical History

Name: _____Today's Date: _____

Address: _____

_____

Home Phone #: _____ _____Work/Cell #:_____

D.O.B.:_____ SSN#: _____

Email: _____

Last Eye Exam: _____ Insurance: _____

Primary Care Physician: _____ __ Phone: _____

Any Known Drug Allergies: _____

List Any Medications You Are Taking: _____
_____
_____

Are you pregnant and/ nursing: Y / N
Do you wear glasses? Y / N Age of glasses _____
Do you currently wear contact lenses? Y / N Type? □Rigid □Soft □Night & Days

Family History
Please Note any family history (parents. Grand parents, siblings, children living or deceased) for the following medical conditions:

		Relationship To You
High Blood Pressure	Y / N	_____
High Cholesterol	Y / N	_____
Diabetes	Y / N	_____
Blindness:	Y / N	_____
Cataract:	Y / N	_____
Crossed Eyes	Y / N	_____
Glaucoma	Y / N	_____
Macular Degeneration	Y / N	_____
Retinal Detachment/Disease	Y / N	_____
Arthritis	Y / N	_____
Cancer	Y / N	_____
Heart Disease	Y / N	_____
Stroke	Y / N	_____

Other: _____

PLEASE COMPLETE 2nd PAGE

Social History

Do you drive? Y / N If yes, do you have visual difficulty when driving? Y / N If yes please describe: _____

Do you smoke? Y / N How Long?_____
Do you drink? Y / N How Often? _____ Do you use illegal drugs? Y / N How long? _____
Have you ever been infected/exposed by?___ Gonorrhea ___ Hepatitis ___ HIV ___ Syphilis

Do you use a computer? How Often daily? _____

Review of Systems

Do you currently have any problems in the following areas?

CONSTITUTIONAL		EARS/NOSE/THROAT	
Fever, Weight Loss/Gain	Y / N	Hay Fever	Y / N
INTEGUMENTARY		Sinus Congestion	Y / N
Skin	Y / N	Chronic Cough	Y / N
NEUROLOGICAL		VASCULAR/CARDIOVASULAR	
Headaches	Y / N	Diabetes	Y / N
Migraines	Y / N	Chest Pain	Y / N
Seizures	Y / N	High Blood Pressure	Y / N
EYES		Vascular Disease	Y / N
Loss of Vision	Y / N	GASTROINTESTINAL	
Blurred Vision	Y / N	Diarrhea	Y / N
Distorted Vision/Halos	Y / N	Constipation	Y / N
Loss of side vision	Y / N	BONES/JOINTS/MUSCLES	
Double Vision	Y / N	Rheumatoid Arthritis	Y / N
Dryness	Y / N	Muscle Pain	Y / N
Mucous Drainage	Y / N	Joint Pain	Y / N
Redness	Y / N	LYMPHATIC/HEMATOLOGIC	
Sandy/Gritting Feeling	Y / N	Anemia	Y / N
Itching/Burning	Y / N	ALLERGIES/IMMUNOLOGIC	
Excess Tearing/Watering	Y / N	Seasonal	Y / N
Eye Pain/Soreness	Y / N	Chronic	Y / N
Glare/Light Sensitive	Y / N	PSYCHIATRIC	
Floaters	Y / N	Anxiety	Y / N
Chronic Infection	Y / N	Depression	Y / N
Decrease in Vision	Y / N	GENITOURINARY	
Flashes of Light	Y / N	Kidney/Bladder	Y / N
ENDOCRINE		RESPIRATORY	
Thyroid/Other Glands	Y / N	Asthma	Y / N
		Emphysema	Y / N

If you answered YES to any of the above or have a condition not listed please explain as well as any surgeries/hospitalizations:

_____
_____
_____