NAME_____ DATE_____

Date of birth _____

Who referred you to the office? _____

Who is your primary Doctor? _____

OCULAR HISTORY:
Have you ever been told you have:

Cataracts ***YES*** ***NO*** When? _____
Glaucoma ***YES*** ***NO*** How long? _____
Macular Degeneration ***YES*** ***NO*** How long? ____
Retinal Detachment ***YES*** ***NO*** When? _____
Other_____

Has anyone in your family (blood relatives) had any eye problems:

Cataracts ***YES*** ***NO***
Glaucoma ***YES*** ***NO***
Macular Degeneration ***YES*** ***NO***
Blindness ***YES*** ***NO***
Retinal Detachment ***YES*** ***NO***
Other_____

Medical history:
Have you ever been told you have:

Diabetes ***YES*** ***NO*** How long? _____
Hypertension ***YES*** ***NO*** How long? _____
Heart problems ***YES*** ***NO*** When? _____
Cholesterol ***YES*** ***NO***
Bleeding disorders ***YES*** ***NO***
Aids or HIV ***YES*** ***NO***

Has anyone in your family (blood relatives) had any
Of these conditions:
Diabetes ***YES*** ***NO***
Who? _____
Hypertension ***YES*** ***NO***
Who? _____

Please list:
Your eye medications:
_____
_____
_____
_____

List any other medications given to to you by your family Dr. including Aspirin:
_____
_____
_____
_____

Major medical conditions:
Cancer _____
Heart attack _____
Thyroid problems _____
Breathing or lung problems
_____
Other _____
_____
_____

Allergic to medications
Iodine ***YES*** ***NO***
Penicillin ***YES*** ***NO***
Sulfa ***YES*** ***NO***
Others _____
_____
_____

Social history:
Do you smoke? ***YES*** ***NO***
how much? _____
Drink alcohol ***YES*** ***NO***
how much? _____

Occupation _____

CONTINUE >>

HAVE YOU HAD OR ARE YOU HAVING ANY OF THESE SYMPTOMS CURRENTLY?

REVIEW OF SYSTEMS

CONSTITUTIONAL SYSTEMS YES NO
Fever …… ___ / ___
Weight loss…… ___ / ___
Other _____
_____

EYES YES NO
Blurry vision…… ___ / ___
Burning…… ___ / ___
Do you have difficulty reading small print? ..... ___ / ___
Other _____
_____

EARS, NOSE, MOUTH, THROAT YES NO
Sinus Congestion…… ___ / ___
Dry throat—mouth…… ___ / ___
Other _____
_____

CARDIOVASCULAR YES NO
Congestive heart failure…… ___ / ___
Heart attacks…… ___ / ___
Irregular—fast heartbeat…… ___ / ___
Blood pressure…… ___ / ___
Other _____
_____

RESPIRATORY YES NO
Asthma…… ___ / ___
Emphysema…… ___ / ___
Other _____
_____

GASTROINTESTINAL YES NO
Jaundice—hepatitis…… ___ / ___
Cancer…… ___ / ___
Other _____
_____

GENITOURINARY YES NO
Kidney disease…… ___ / ___
Other _____
_____

INTEGUMENTARY (skin and/or breast) YES NO
Skin disease…… ___ / ___
Breast cancer…… ___ / ___
Other _____

MUSCULO—SKELETAL YES NO
Rheumatoid arthritis…….. ___ / ___
Lupus…… ___ / ___
Other _____
_____

NEUROLOGICAL YES NO
Dizziness…..... ___ / ___
Migraines…… ___ / ___
Other _____
_____

PSYCHIATRIC YES NO
Depression……..... ___ / ___
Schizophrenia…… ___ / ___
Other _____
_____

HEMATOLOGICAL/LYMPHATIC YES NO
Anemia…… ___ / ___
Bleeding disorder…… ___ / ___
Other _____
_____

ALLERGIC/IMMUNOLOGIC YES NO
Head allergy symptoms…..... ___ / ___
Seasonal allergies…… ___ / ___
Other _____
_____

ENDOCRINE YES NO
Diabetes…… ___ / ___
Cancer-pancreas/adrenal glands…… ___ / ___
Thyroid problems..... ___ / ___
Other _____
_____