

Patient Information

Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 DOB _____ Age _____ Social Security # _____
 Phone _____ Email _____

Past, Medical, Family and Social History:

Occupation: _____ Employer: _____
 Work on computer? No Yes Difficulty seeing to drive? No Yes Difficulty reading? No Yes
 Current Medications: _____
 Allergies to medications? No Yes If yes, list meds _____
 Describe any history of eye-related trauma, surgery, illness, disease, or problems: _____

 List diseases or health problems of parents and siblings: _____

Parent or Sibling with any of the following? Glaucoma Diabetes Macular Degeneration Retinal Disease
 Are you pregnant and/or nursing? No Yes Check if ever exposed: Hepatitis HIV Syphilis Tuberculosis
 Do you use tobacco products? No Yes Do you drink alcohol? No Yes

Review of Systems:

Please check current and chronic symptoms and conditions:

	Yes	No		Yes	No
Constitutional			Cancer		
Fever	<input type="radio"/>	<input type="radio"/>	Skin / Melanoma	<input type="radio"/>	<input type="radio"/>
Weight Gain/Loss	<input type="radio"/>	<input type="radio"/>	Lymphatic / Hematologic		
Eyes			AIDS	<input type="radio"/>	<input type="radio"/>
Blurred Vision	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>
Burning or Irritation	<input type="radio"/>	<input type="radio"/>	Bleeding Disorders	<input type="radio"/>	<input type="radio"/>
Cloudy or Hazy Vision	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>
Distorted Vision	<input type="radio"/>	<input type="radio"/>	Herpes	<input type="radio"/>	<input type="radio"/>
Double Vision	<input type="radio"/>	<input type="radio"/>	HIV Positive	<input type="radio"/>	<input type="radio"/>
Flashes / Floaters in Vision	<input type="radio"/>	<input type="radio"/>	Liver Disease	<input type="radio"/>	<input type="radio"/>
Foreign Body Sensation	<input type="radio"/>	<input type="radio"/>	Neurologic		
Glare / Light Sensitivity	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>
Itching	<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>
Mucous Discharge	<input type="radio"/>	<input type="radio"/>	Migraines	<input type="radio"/>	<input type="radio"/>
Pain or Soreness	<input type="radio"/>	<input type="radio"/>	Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>
Pressure	<input type="radio"/>	<input type="radio"/>	Seizures	<input type="radio"/>	<input type="radio"/>
Redness	<input type="radio"/>	<input type="radio"/>	Reproductive		
Sandy or Gritty Feeling	<input type="radio"/>	<input type="radio"/>	Nursing Mother	<input type="radio"/>	<input type="radio"/>
Styes or lid bumps	<input type="radio"/>	<input type="radio"/>	Pregnant	<input type="radio"/>	<input type="radio"/>
Tearing / Watering	<input type="radio"/>	<input type="radio"/>	Respiratory		
Bone / Joint / Muscle			Asthma	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>
Back / Jaw / Bone Pain	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>
Joint / Muscle Pain	<input type="radio"/>	<input type="radio"/>	Pneumonia	<input type="radio"/>	<input type="radio"/>
Endocrine			Tuberculosis	<input type="radio"/>	<input type="radio"/>
Hyperthyroid	<input type="radio"/>	<input type="radio"/>	Vascular		
Hypothyroid	<input type="radio"/>	<input type="radio"/>	Cholesterol	<input type="radio"/>	<input type="radio"/>
Ear, Nose, and Throat			Diabetes Type 1	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	Diabetes Type 2	<input type="radio"/>	<input type="radio"/>
Dry Mouth / Throat	<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>
Hay Fever / Sneezing	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Runny Nose	<input type="radio"/>	<input type="radio"/>	Low Blood Pressure	<input type="radio"/>	<input type="radio"/>
Sinus Congestion	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>

Patient Signature: _____ Date: _____