Patient Name: _____ **Today's Date**: ____/____/_____

Date of Birth: ____/____/_____

Allergies to Medication: _____

Past Eye History

Cataracts	Yes	No
Glaucoma	Yes	No
Corneal Dystrophy	Yes	No
Dry Eyes	Yes	No
Amblyopia (lazy eye)	Yes	No
Retinal Detachment	Yes	No
Macular Degeneration	Yes	No
Uveitis	Yes	No
Diabetic Retinopathy	Yes	No

Past Medical History

Hypertension	Yes	No
Cholesterol	Yes	No
Thyroid Disease	Yes	No
Heart Disease	Yes	No
Diabetes	Yes	No
Autoimmune Disease	Yes	No
Horm. Repl. Therapy	Yes	No
Arthritis	Yes	No

Other: _____

Previous Eye Surgery

			Date:	**Which Eye?**	
Cataract Surgery	Yes	No	_____	R	L
Corneal Transplant	Yes	No	_____	R	L
Retinal Surgery	Yes	No	_____	R	L
Strabismus	Yes	No	_____	R	L
Glaucoma Surgery	Yes	No	_____	R	L
Lasik/PRK/RK	Yes	No	_____	R	L

Other Surgical History: _____

Social History

Do You Smoke? Yes No
How Many Packs per Day: _____
Do You Drink? Yes No
How Often: _____
Drugs? Yes No
How Often: _____

Medications List: _____
_____

Review Of Systems: (Please Circle the Symptoms that Apply to You)

- **Constitutional:** Fever, Chills, Weight loss, Fatigue, Perspiration (diaphoresis), Weakness
- **Skin**: Rash, Irritation
- **Head/Ear/Nose/Throat:** Headaches, Hearing loss, Tinnitus (ringing in ears), Ear pain, Ear discharge, Nosebleeds, congestion, Harsh sound heard when inhaling (stridor), Sore throat
- **Eyes:** Blurred vision, Double vision, Sensitivity to light (photophobia), Eye pain, Eye discharge, Eye redness
- **Cardiovascular:** Chest pain, palpitations, Difficulty breathing when laying down (orthopnea), Leg pain (claudication), Leg swelling, Shortness of breath that wakes you from sleep (PND)
- **Respiratory:** Cough, Blood with cough (hemoptysis), Sputum production, Shortness of breath, Wheezing
- **Gastrointestinal:** Heartburn, Nausea, Vomiting, Abdominal pain, Diarrhea, Constipation, Blood in stool, Black stool (melena)
- **Genitourinary:** Painful or difficult urination (dysuria), Urgent or frequent urination, Blood in urine (hematuria), Flank pain
- **Musculoskeletal:** Pain in muscles (myalgia), Neck pain, Back pain, Joint pain, Falls
- **Endocrine/Allergy/Heme:** Easy bruising or bleeding, Environmental allergies, Excessive thirst (polydipsia)
- **Neurological:** Dizziness, Tingling, Tremors, Sensory changes, Speech changes, Focal weakness, Seizures, Loss of consciousness (LOC)
- **Psychiatric:** Depression, Suicidal thoughts or ideas, Substance abuse, Hallucinations, Nervousness/Anxiety, Insomnia, Memory Loss

Family History:

			Which Blood Relative?		
Cataracts	Yes	No	_____	Maternal	Paternal
Glaucoma	Yes	No	_____	Maternal	Paternal
Macular Degeneration	Yes	No	_____	Maternal	Paternal
Hypertension	Yes	No	_____	Maternal	Paternal
Heart disease	Yes	No	_____	Maternal	Paternal
Diabetes	Yes	No	_____	Maternal	Paternal
Cancer	Yes	No	_____	Maternal	Paternal

❖ **If relative is not a parent or a sibling, please circle whether it's on your maternal or paternal side**

Is your living environment unsafe or threatening? Yes No
Do you have a relationship with someone who physically hurts or threatens you? Yes No
Is anyone misusing your money, food, housing, or not allowing you to receive medical treatment? Yes No