Full Name: _____ Birth Date: ____/____/____

Marital Status: Single / Married / Divorced / Widowed Spouse Name: _____

Currently Working: Yes ___ No ___ Retired ___ Occupation: _____

Previous Eye Doctor: _____ Last Eye Exam: ____/____/____

Medical Doctor: _____ Last Medical Exam: ____/____/____

What is your primary concern for your visit today? _____

_____

Are you currently experiencing any problems with your eyes? Yes ____ No to all ____ If yes, please complete:

Symptom	Right Eye	Left Eye	Severity	Duration of problem
Blurred vision			Mild /Moderate /Severe/ Intense /Varies	Unsure /Day /Week /Month /Year /Years
Loss of vision			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Floaters			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Flashers			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Curtain over vision			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Pain			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Light sensitivity			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Red Eye			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Tearing			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Lid crusting			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Foreign body			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Discharge			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Glare			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Pressure sensation			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Double vision			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years
Lid swelling			Mild /Moderate /Severe /Intense /Varies	Unsure /Day /Week /Month /Year /Years

Is your distance vision worse than your near vision? Yes ___ No ___
If your near vision worse than your distance vision? Yes ___ No ___
Is your vision worse late in the day? Yes ___ No ___
Is your vision worse at night? Yes ___ No ___

MEDICAL HISTORY:
Have you been *diagnosed* with any of the medical conditions below? If yes, please circle No to all ____

Cataracts	Diabetes Type I	Macular Degeneration	Retinal Detachment
Dry Eye	Diabetes Type II	Keratoconus	Retinal Tear
Glaucoma	Diabetic retinopathy	Migraines	Macular Hole
Hypertension	Bell's Palsy	Atrial Fibrillation	Sleep Apnea
Stroke	Sjogren's Syndrome	Cancer	Psoriasis
Kidney Failure	Crohn's Disease	COPD	Anemia/Bleeding Problems
Bipolar/Depression	Muscular Dystrophy	Asthma	Acid Reflux Disease
Osteoarthritis	Rheumatoid Arthritis	Emphysema	Lupus

OCULAR SURGICAL HISTORY:
Have you had eye *surgery* in the past including Cataract, Vitrectomy, Laser, Glaucoma, Refractive Surgery?
Yes ___ No ___ If yes, please list:

Procedure Date Which Eye Procedure Reason

OTHER SURGICAL HISTORY:
Have you had any other *surgical* procedures in the past? Yes ___ No ___ If yes, please list:
Procedure Date Procedure

Have you received the Pneumococcal Vaccine? Yes ____ No ____
Do you receive yearly Influenza Immunizations? Yes ____ No ____

Do you have any allergies? Yes ____ No ____ If yes, please list
Medication Reaction Severity of Reaction

	Mild	Moderate	Severe
	Mild	Moderate	Severe
	Mild	Moderate	Severe
	Mild	Moderate	Severe
	Mild	Moderate	Severe

Are you on any blood thinners? Yes ____ No ____ If yes, please list
Medication Reason

Are you a diabetic? Yes ____ No ____ If yes, what was your last A1C_____

FAMILY HISTORY:
Do you have a family history (parents, grandparents, siblings, children: living or deceased) of any of the medical conditions below? If yes, please write in the relationship No to all ____

	Relation to You		Relation to You
Retinal Detachment	_____	Marfan syndrome	_____
Glaucoma	_____	Strabismus	_____
Retinitis Pigmentosa	_____	Macular Degeneration	_____

SOCIAL HISTORY:
Do you currently smoke? Yes ____ No ____ Do you smoke every day? Yes ____ No ___
Have you smoked in the past? Yes ____ No ____
Do you drink alcohol? Yes ____ No ____ Occasional ____ 1-2 Drinks/day ____ 3-4 Drinks/day ____

REVIEW OF SYSTEMS:
Are you *currently* experiencing any of the following problems? If yes, please circle No to all ____

Allergy/Immunology:	Autoimmune disease	Hematology/Oncology:	Easy bruising
	Seasonal allergies		Prolonged bleeding
Cardiovascular:	Chest pain	Head/Ears/Nose/Throat:	Hearing loss
	Irregular heart beat		Sore throat
	Blood pressure stable	Integumentary:	Skin rash
	Blood pressure uncontrolled		Skin sores
Constitutional:	Unexplained weight loss	Musculoskeletal:	Joint pain
	Loss of appetite		Back pain
Endocrine:	Excess thirst	Neurologic:	Headaches
	Hair loss		Dizziness
Gastrointestinal:	Nausea	Psychiatric:	Bipolar
	Abdominal pain		Depression
Genitourinary:	Dialysis	Respiratory:	Difficulty breathing
	Problems urination		Cough

GLASSES:
Do you wear glasses? Yes ___ No ___ If yes, how old is your present pair of glasses? _____
Do you wear your glasses all the time? Yes ___ No ___
Do you wear your glasses only for close-up work? Yes ___ No ___
Do you do a lot of computer work? Yes ___ No ___

CONTACT LENSES:
Do you wear contact lenses? Yes ___ No ___
If yes, what type? RGP ___ Soft ___ Toric ___ Multifocal ___ Monovision ___
Do you wear them: Full time ___ Part time ___ How frequently do you replace them? _____
How many hours per day do you wear them? _____
Do you take them out at night? Yes ___ No ___
What solution do you use? _____

MEDICATIONS

Help us take better care of you by updating your medications, allergies, and tobacco use at every appointment! Please list all medication prescribed by your physicians, vitamins or herbal supplements, over-the-counter medications, and homeopathic medications. Use more copies if necessary.

Name of Pharmacy _____

Medication (Prescriptions, Eye Drops, over-the-counter, vitamins, supplements)	**Dosage** (Amount: mg, ml, units, drops, etc.)	**Route** (By mouth, applied to skin, drops in eye)	**Frequency** (How often do you take this?)