Your Medical History & Review of Systems

Cardiovascular	Yes	**Immunologic**	Yes
- Arrhythmias	___	- AIDS/HIV	___
- Cardiovascular Disease	___	- Herpes Simplex	___
- Stroke / Mini Stroke	___	- Herpes Zoster	___
- High Blood Pressure	___	- Sjogren's	___
- High Cholesterol	___	- Lupus	___
Symptoms? ________________		Symptoms?_____________	
Constitutional	Yes	**Integumentary** (skin)	Yes
- Fainting	___	- Acne Rosacea	___
- Excessive Thirst	___	- Dermatitis	___
- Weight gain/loss	___	- Psoriasis	___
Symptoms?________________		Symptoms?_____________	
Endocrine	Yes	**Musculoskeletal**	Yes
- Diabetes	___	- Ankylosing Spondylitis	___
-Year Diagnosed: __________		- Rheumatoid Arthritis	___
- Treating Dr:___________		- Myasthenia Gravis	___
- Thyroid Disorder	___		
- Pituitary Disorder	___	Symptoms?______________	
Symptoms?________________			
Gastrointestinal	Yes	**Neurological**	Yes
- Acid Reflux	___	- Bell's Palsy	___
- Stomach Ulcers	___	- Multiple Sclerosis	___
- Other:______________	___	- Parkinson's	___
		- Seizure Disorder	___
Symptoms?________________		Symptoms?______________	
Genitourinary	Yes	**Psychiatric**	Yes
- Prostate Disorder	___	- Alzheimer's	___
- Sexually Trans. Disease	___	- Dementia	___
- Kidney Stones	___	- Mood Disorder	___
Symptoms?________________		Symptoms?______________	
Head	Yes	**Respiratory**	Yes
- Dry mouth	___	- Asthma	___
- Headache/Migraine	___	- COPD	___
- Hearing Impaired	___	- Emphysema	___
		- Sleep Apnea	___
Symptoms?________________		Symptoms?______________	
Hematologic/Lymphatic	Yes	**Other**	Yes
- Cancer __________	___	-Pregnant	___
Type & Year: __________		________________________	
- Anemia	___	________________________	
- Temporal Arteritis	___	________________________	
Symptoms?________________			

List Your Medications & Supplements – include dosage & frequency

Today's Date: _________
Name: ______________________
Date of Birth: ________ **Gender**:
Primary Care Doctor:____________________
Referring Doctor:______________________
Last Eye Exam (approx)**:**__________________

Your Eye History

	Yes
Dry Eye	
Crossed Eye or Lazy Eye	
Double Vision	
Eyelid Crusting / Blepharitis	
Flashes / Floaters	
Glaucoma	
Cataracts	
Macular Degeneration	
Retinal Problem (other)	
Corneal Disease	
Other:	

Eye Surgeries
Cataract Surgery: Year: ________
Name of Surgeon:
Did you have a follow up Laser?

Type of Laser Surgery: Year:
Name of Surgeon: ____________________

Other Eye/Laser Surgery:
Retina:
Eye: Right Left Both Year:_____ Surgeon: ___________
Glaucoma:
Eye: Right Left Both Year:_____ Surgeon: ___________
Eye Muscle:
Eye: Right Left Both Year:_____ Surgeon: ___________

List Major Non-Eye Surgeries & Year Performed

List Your Eye Medications

List Your Medication Allergies

List Your Non-Medication Allergies

Do you CURRENTLY take:
Aspirin Coumadin Plaquenil Plavix Prednisone

Have you EVER taken:
Flomax (Tamsulosin) Hytrin (Terazosin)

Your Family Eye History - List Who

	Yes
Blindness:	
Crossed Eye/Eye Turn:	
Lazy Eye:	
Cataracts:	
Glaucoma:	
Macular Degeneration:	
Retinal Problem (other):	
Corneal Disease:	
Other:	

Your Family Health History – List Who

	Yes
Diabetes:	
High Blood Pressure:	
High Cholesterol:	
Cancer:	
Other:	

Your Social History

	Yes
Never Smoked	
Former Smokers, when did you quit? :	
Current Smokers, packs per day? : For how many years?:	
Current Smokeless Tobacco Use	
No Alcohol Use	
Social Alcohol Use Only	
1-2 Alcoholic Drinks Daily	
Excessive Alcohol Use	

Glasses

	Yes
- Do you wear glasses?	___
- All the time	___
- Distance/Driving only	___
- Reading only	___
How old are your glasses: ________________	
Are you happy with your glasses:	
Where did you purchase your glasses: ____	

Contact Lenses

	Yes
- Do you wear contact lenses?	___
- Soft	___
- Hard/Rigid Gas Permeable	___
- For Astigmatism?	___
- Bifocal?	___
- Monovision?	___
What brand do you wear: ____	
How often do you replace your lenses: ____	
How many hours do you wear your lenses: ____	
How often do you sleep in your lenses: ____	
What brand solution do you use: ____	
Are you happy with your current contacts?	

OFFICE USE ONLY:

Physician & Technician Review	Date

____

Physician Signature