

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_



**Social History:**

Do you use tobacco?  Never  Quit (Date: \_\_\_\_\_)  Passive  Yes

Packs per day: \_\_\_\_\_ # of years: \_\_\_\_\_

Type(s) of tobacco? \_\_\_\_\_

Do you drink alcohol?  Yes  No

Drinks per day: \_\_\_\_\_ Drinks per week: \_\_\_\_\_

Do you consume caffeine?  Yes  No

Number of cups: \_\_\_\_\_

Do you use recreational drugs?  Yes  No

Uses per week: \_\_\_\_\_ Types: \_\_\_\_\_

**Allergies**

Check all that apply:  Penicillin  Sulfa  Codeine  None

Other Allergies: \_\_\_\_\_

**Eye Health:** (please circle all that apply)

Blurred Vision	Right	Left	Flashes of Light	Right	Left
Loss of Vision	Right	Left	Floaters	Right	Left
Distorted/wavy vision	Right	Left	Shadows	Right	Left
Eye Pain or Soreness	Right	Left	Glare or Sensitivity to Light	Right	Left
Excess Tearing or Watering	Right	Left	Mucous Discharge	Right	Left
Redness	Right	Left	Itching	Right	Left

**Medications:**

Name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Direction: \_\_\_\_\_

Name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Direction: \_\_\_\_\_

Name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Direction: \_\_\_\_\_

Name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Direction: \_\_\_\_\_

Name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Direction: \_\_\_\_\_

**Eye Health History**

Condition: \_\_\_\_\_

Date: \_\_\_\_\_

Procedure: \_\_\_\_\_

Which Eye? \_\_\_\_\_

Condition: \_\_\_\_\_

Date: \_\_\_\_\_

Procedure: \_\_\_\_\_

Which Eye? \_\_\_\_\_

Condition: \_\_\_\_\_

Date: \_\_\_\_\_

Procedure: \_\_\_\_\_

Which Eye? \_\_\_\_\_

## History of Illness and/or Operations

Condition: \_\_\_\_\_ Date: \_\_\_\_\_

Procedure: \_\_\_\_\_

Condition: \_\_\_\_\_ Date: \_\_\_\_\_

Procedure: \_\_\_\_\_

Condition: \_\_\_\_\_ Date: \_\_\_\_\_

Procedure: \_\_\_\_\_

## Medical History (please circle all that apply)

Yes No **General- Constitutional:** Headaches, fatigue, insomnia, weight loss, weight gain, unusually tired, heat stroke  
If yes, explain: \_\_\_\_\_

Yes No **Ear- Nose- Throat:** Hearing loss, stuffy nose, ear ache, cough, dry mouth, vertigo, etc.  
If yes, explain: \_\_\_\_\_

Yes No **Cardiovascular:** Chest pain, high blood pressure, irregular heartbeat, palpitations, stroke, etc.  
If yes, explain: \_\_\_\_\_

Yes No **Respiratory:** Asthma, shortness of breath, exposure to Tuberculosis, etc.  
If yes, explain: \_\_\_\_\_

Yes No **Gastrointestinal:** Diarrhea, constipation, hernia, ulcer(s), nausea, vomiting, reflux, etc.  
If yes, explain: \_\_\_\_\_

Yes No **Genitourinary:** Kidney stones, blood in urine, etc.  
If yes, explain: \_\_\_\_\_

Yes No **Reproductive:** Are you pregnant? Are you nursing?  
If yes, explain: \_\_\_\_\_

Yes No **Musculoskeletal:** Arthritis, back pain, bone/joint pain, rheumatoid arthritis, sjogrens, etc.  
If yes, explain: \_\_\_\_\_

Yes No **Dermatologic:** Acne, warts, growth, rash, etc.  
If yes, explain: \_\_\_\_\_

Yes No **Neuro- Pyschiatric:** Numbness, seizures, paralysis, Alzheimer's, anxiety, depression, dementia, Parkinson's, Multiple Sclerosis, memory loss, etc.  
If yes, explain: \_\_\_\_\_

Yes No **Metabolic- Endocrine:** Diabetes, hypothyroid, kidney failure, kidney removal, etc.  
If yes, explain: \_\_\_\_\_

Yes No **Hematology:** Bleeding, anemia, bruise easily, blood clots, high cholesterol, etc.  
If yes, explain: \_\_\_\_\_

Yes No **Allergy- Immunologic:** Sneezing, swelling, itching, hives, Lupus, etc.  
If yes, explain: \_\_\_\_\_

## Family History (please indicate if any of your family members have any of the following.)

	Mother	Father	Brother/Sister	Grandparent
Glaucoma				
Macular Degeneration				
Thyroid Disease				
Diabetes				
Lazy Eye				
Hypertension				
Stroke				
Cancer				

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_