

Visit Date
 Referred By
 Referral Phone
 Date of Birth
 Male or Female (circle one)

Patient Name
 Primary Care Physician
 PCP Phone

Address
 Home Phone

City, State
 Zip
 Cell Phone

Medical History

Medications

None Taken or *List Below*

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Reason for</u>

EYE Medications

None Taken or *List Below*

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Reason for</u>

Allergies

None Known Latex

Drugs: _____

Food: _____

Eye History

Wear **Glasses** for (circle all that apply)? Nearsightedness Farsightedness Astigmatism Reading

Wear **Contacts** for (circle all that apply)? Nearsightedness Farsightedness Astigmatism Reading

Glaucoma
 Lazy Eye
 Injury
 Macular Degeneration
 Cataract

List Others Below

<u>Eye Surgery, Event or Disease</u>	<u>R eye</u>	<u>L eye</u>	<u>Date</u>

Illnesses

- Diabetes Heart Disease Asthma High Blood Pressure Emphysema Stroke
 Cancer Arthritis COPD High Cholesterol CHF Sleep Apnea (C-Pap machine?)
 None or *List Others*
-
-

Surgery

- Tonsils Appendectomy Heart Gallbladder None or *List Others*
-
-

Family History	Relationship to Patient				Relationship to Patient							
	Y	N	Mother	Father	Sibling	Grandparent	Y	N	Mother	Father	Sibling	Grandparent
Blindness												
Glaucoma												
Arthritis												
Cancer												
Diabetes												

Review of Systems	Y	N	If YES, Please Explain
General / Constitutional (fever, weight loss, obesity, etc)			
Integumentary / Skin (rashes, growths, hair loss, etc)			
Ears (hearing loss, drainage, etc)			
Neck (swollen glands, thyroid, etc)			
Respiratory (congestion, wheezing, COPD, etc)			
Cardiovascular (high B/P, racing pulse, etc)			
Gastrointestinal (stomach upset, diarrhea, constipation, etc)			
GenitoUrinary (painful or frequent urination, impotence, etc)			
MusculoSkeletal (joint pain, stiffness, swelling, cramps, etc)			
Neurological (seizures, convulsions, numbness, headache, weakness, etc)			
Endocrine (bruising, diabetes, hypothyroid, etc)			
Hemato-Immunologic (anemia, high cholesterol, bleeding tendencies, etc)			
Psychiatric (anxiety, depression, insomnia, etc)			

Do you drink alcohol? If Yes: occasionally 1/day 2-3/day 4+/day
 Do you smoke? If Yes: occasionally 1/2 pack/day 1 pack/day 1+packs/day

Current Occupation: _____

Patient Signature: _____