EYE HISTORY

Patient Name: _____ **Date:** _____

Current / Previous Eye Doctor: _____ **Last Exam:** _____

History of Vision Problems (please circle all that apply): _____ **No previous history**

Amblyopia/Lazy Eye	Blurred Vision	Cataracts
Contact Lenses	Corneal Abrasion	Decreased/Fluctuating Vision
Diabetic Retinopathy	Discharge/Mattering	Double Vision
Droopy Lid	Dry Eye	Flashing Lights
Foreign Body Sensation	Glare/Haloes	Glasses
Glaucoma	Headaches	Herpes (fever blisters)
Itching/Irritation	Keratoconus	Light Sensitivity
Macular Degeneration	New Floaters	Retinal Tear/Detachment
Redness	Side Vision Loss	Strabismus
Trauma/Scar/Foreign Body	Uveitis	

History of Eye Surgery (please specify which eye and date of surgery): _____ **No previous surgery**

PRK _____ Muscle _____

Retinal _____

Cataract _____

RK/AK _____ LASIK/ALK _____

Corneal Transplant _____ Other _____

History of Contact Lens Use: _____ No previous history _____ # of years used

Soft Toric Lenses Soft Lens--Daily Wear Soft Lens--Overnight Wear Gas Permeable (PMMA)

What lenses are you currently wearing? _____

What is your normal wearing schedule? _____

Updated _____ _____ _____ _____ _____ _____

MEDICAL HISTORY

Patient Name: _____ **Date:**_____

Primary Care Physician: _____ **Pharmacy**_____

Current Medications: _____None (You may provide a written list to scan into your chart):

List name, dosage & frequency: _____

_____

_____

Current vitamins and supplements:_____

_____

MEDICATION ALLERGIES _____None Please list medication, location of reaction (skin, systemic, local abdominal), severity of reaction (mild, moderate or severe) and symptoms_____

_____

_____

_____

GENERAL HEALTH HISTORY: **(circle all that apply)** No previous history Arthritis

Hepatitis High blood pressure Asthma Lupus Diabetes HIV

Healing problems/Keloids Pacemaker Thyroid Migraines Cancer

High cholesterol Stroke Alzheimer's or memory loss

Women Only: Are you currently pregnant or breastfeeding? Yes / No

Past Surgeries/Dates: _____

_____

_____

Do you: (1) Smoke? Never/ Yes, but stopped in _____/Yes _____ packs/day for _____ years

(2) Drink alcohol? No / Yes Socially _____ Rarely_____ or _____drinks/week for____ years

(3) Use drugs? No / Yes _____

Do you live: Alone _____ With spouse _____ Other _____

Updated _____ _____ _____ _____ _____ _____

REVIEW OF SYSTEMS

Patient Name: _____ **Date:** _____

Please circle any of the following symptoms or problems that are *currently* affecting you:

Constitutional: Chills Fever Headaches Insomnia Night Sweats

Ear/Nose/Throat: Earaches Hearing loss Sore throat Sinus Ringing in ears Dizziness

Cardiovascular: Chest pain High blood pressure High cholesterol Swelling of feet
Irregular heartbeat / Palpitations Slow / Fast heart rate

Respiratory: Asthma Cough Shortness of breath Tuberculosis

Gastrointestinal: Abdominal Pain Diarrhea/Constipation Heartburn Hepatitis Ulcers
Jaundice Nausea Reflux Vomiting

Genitourinary: Frequent urination Hesitancy Impotence Incontinence
Infections Kidney stones Pain Sexually transmitted disease

****Do you take Flomax or any other medicine for urinary frequency?** Yes / No

Musculoskeletal: Arthritis Gout Low back pain Muscle aches/cramps

Skin: Breast cancer Dermatitis Dry skin Eczema Hives
Pigmented lesions Rosacea Rashes Skin cancer Masses/Tumors

Neurological/Psychiatric: Weakness Headaches Memory loss Multiple Sclerosis
Numbness Paralysis Seizures Hallucinations Anxiety/Depression

Endocrine: Cold/Heat intolerance Diabetes Hypoglycemia Hyperthyroid/Hypothyroid

Hematologic (blood)/Lymphatic: Easy bleeding/Bruising Swollen glands Anemia

Immunologic: Asthma Hay fever Hives Rashes Lupus

Family History: None Amblyopia Blindness Cancer Cataracts Crossed Eyes
Diabetes Diabetic Retinopathy Glaucoma Heart Disease High Blood Pressure
Macular Degeneration Retinal Detachment Stroke Other_____

Is there anything else not listed that we should know in order to treat you today? _____

_____

_____

Updated: _____ _____ _____ _____ _____ _____