|  |
| --- |
| Patient Name: Today’s Date: |
| Date of Birth: Date of Last Eye Exam:  |
| **Eye Medications:** 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_**\*Please bring your eye medications and current glasses with you, as well as a list of your other medications\*****Other Medication:** (include any prescriptions or over the counter medications)1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you **allergic** to any medications? **YES or NO**If **yes** please list the medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any adverse reactions to **anesthesia**? **YES or NO** If yes please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please list **all operations** (cataract, appendectomy, etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Past Medical History**

|  |  |  |
| --- | --- | --- |
| **Y N Eye History**Contact lenses  Glasses Poor reading vision GlaucomaLazy eyeCrossed eyeKeratoconusCataractsDry eyesRetinal DetachmentPoor distance visionMacular DegenerationOther:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Y N Health History**Diabetes  Stroke Cancer EmphysemaHeart DiseaseHigh Blood PressureAsthmaThyroid DiseaseRheumatoid Arthritis DepressionHIV/AIDSHeadachesOther:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Y N Family History**Corneal Dystrophy  Blindness Corneal Transplants CataractsGlaucomaColor BlindnessLazy EyeCrossed EyesRetinal disease or detachmentDiabetesOther known medical problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Social History****Tobacco:** Never Smoked Ex-Smoker Current Smoker**Alcohol Consumption**: Never Occasional Frequent  |
|  ROS Y N Do you ***CURRENTLY*** have any problems in the following areas?

|  |  |  |  |
| --- | --- | --- | --- |
| Constitutional |  |  | Weight loss Fevers Weakness Fatigue Weight gain Night Sweats  |
| EYE |  |  | Blurry vision Eye pain Eye discharge Eye redness Decrease in vision Dry eyes Double Vision  |
| ENT |  |  | Sore Throat Lump in Neck Hearing loss Nasal Congestion Vertigo Tinnitus Sinus Problems Hoarseness  |
| Cardiovascular |  |  | Chest Pressure/ Discomfort Irreg. Heartbeats/ Palpitations Rapid heart Rate Heart murmur Calf Pain Swelling in the legs or feet  |
| Respiratory |  |  | Shortness of breath Chronic cough Asthma Wheezing Coughing Up Blood  |
| Skin |  |  | Rash Hives Hair loss Skin sores Ulcers Skin Changes Skin Lesions Skin Nodules Dry Skin Itching Skin Nail Changes  |
| Musculoskeletal |  |  | Joint Swelling Muscle Cramping Joint Pain Muscle Weakness Fractures Joint Stiffness Back pain  |
| Endocrine |  |  | Excessive Thirst Heat intolerance Cold intolerance Excessive Hunger Excessive Urination  |
| Neurological |  |  | Seizures Tremors Migraines/ Headaches Numbness Dizziness Loss of balance Slurred speech Stroke Memory Difficulty  |
| Immunologic |  |  | Environmental Allergies Food Allergies Seasonal Allergies   |
| Hem/Lymphatic |  |  | Bruising Swollen Lymph Nodes Tender Lymph Nodes Bleeding  |

**Primary Care Physician and Office Location:** **Additional Information:** Use this space to provide any additional information which may be important to your health care.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Reviewing Physician Date Printed Patient Name Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Reviewing Technician Date Signature of Patient / Guardian Date |