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| 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  Glaucoma  Lazy eye  Crossed eye  Keratoconus  Cataracts  Dry eyes  Retinal Detachment  Poor distance vision  Macular Degeneration  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Y N Health History**  Diabetes  Stroke  Cancer  Emphysema  Heart Disease  High Blood Pressure  Asthma  Thyroid Disease  Rheumatoid Arthritis  Depression  HIV/AIDS  Headaches  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Y N Family History**  Corneal Dystrophy  Blindness  Corneal Transplants  Cataracts  Glaucoma  Color Blindness  Lazy Eye  Crossed Eyes  Retinal disease or detachment  Diabetes  Other 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 |