Name: _____ Date: ____/____/___

Who referred you to us? _____

Primary eye doctor: _____

Primary care provider (PCP): _____

Endocrinologist (diabetes doctor): _____

Chief Complaint: What's the main reason you are being examined today?

History of Present Illness: Tell us a little more about your problem:

Your Ocular and Family Histories: (CIRCLE all that apply)

Your Ocular History

Do you wear? Glasses / Contacts / None

Do you have a history of (if yes, please describe)?

Cataracts:	No / Yes:
Dry eyes:	No / Yes:
Glaucoma:	No / Yes:
Keratoconus:	No / Yes:
Macular degeneration:	No / Yes:
Retinal detachment:	No / Yes:
Other:	

Your Family's Ocular History

Please list any blood relatives (parents or siblings), giving their relation and age when diagnosed for any of the following:

Cataracts:

Dry eyes:

Glaucoma:

Keratoconus:

Macular degeneration:

Retinal detachment:

Other:

Miscellaneous Ocular History (if yes, please describe):

Prior vision correction surgery:	No / Yes:
Prior eye injury:	No / Yes:
Do you experience glare?	No / Yes:
Lazy eye:	No / Yes:

Do you wear contact lenses? No / Yes:

Contact lens type:

Soft: Daily / Toric / Extended wear

Hard: Gas permeable / PMMA

Contact lens wearer for how many years:

Average daily wearing time:

Do you sleep in your contacts?

Current contact prescription (if known):

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Your General Health and Family Histories: (CIRCLE all that apply)

Your Medical Conditions

Do you have a history of (if yes, please describe)?

High blood pressure: No / Yes:

Heart problems: No / Yes:

Arthritis: No / Yes: Rheumatoid / Osteo

Lung problems: No / Yes:

Stroke: No / Yes:

Thyroid problems: No / Yes:

Diabetes: No / Type 1 / Type 2
Diet / Pills / Insulin
Year diagnosed?
Last blood sugar?
Last A1C?

High LDL/Cholesterol: No / Yes:

Ulcers: No / Yes:

Cancer: No / Yes:

Your Family's Medical Conditions

Please list any blood relatives (parents or siblings), giving their relation and age when diagnosed for any of the following:

High blood pressure:

Heart problems:

Arthritis:

Lung problems:

Stroke:

Thyroid problems:

Diabetes:

High LDL/Cholesterol

Ulcers:

Cancer:

Other:

Other:

- ❑ Cardiac valvular disease
- ❑ Sarcoidosis
- ❑ Sleep apnea
- ❑ Hepatitis/liver disease
- ❑ Colon polyps
- ❑ Crohn's disease
- ❑ Ulcerative colitis
- ❑ Prostate problems
- ❑ Kidney failure
- ❑ Anemia
- ❑ Clotting/Bleeding problems
- ❑ Sickle cell disease
- ❑ HIV/AIDS
- ❑ Lupus/SLE
- ❑ Multiple sclerosis
- ❑ Pseudoxanthoma elasticum
- ❑ Seizure disorder
- ❑ Dementia/Alzheimer's
- ❑ Depression
- ❑ Mental retardation
- ❑ Schizophrenia
- ❑ Recent/persistent cough
- ❑ Night sweats
- ❑ Loss of appetite
- ❑ Active Tuberculosis
- ❑ Other:

Pregnancy: (CIRCLE all that apply)

No / Yes: Are you pregnant? Due date:

No / Yes: Are you lactating?

No / Yes: Are you planning on becoming pregnant within the next 3 months?

Vaccines:

Flu: When was your last vaccine?

Pneumococcal: When was your last vaccine?

Review of Systems: Do you have any of the following?

- ❑ Seasonal allergies
- ❑ Hay fever
- ❑ Chest pain
- ❑ Congestive heart failure
- ❑ Irregular heartbeat
- ❑ Fever
- ❑ Skin disease
- ❑ Weight loss
- ❑ Rash
- ❑ Vomiting
- ❑ Bloody stools
- ❑ Stomach ulcers
- ❑ Diarrhea
- ❑ Genital ulcers
- ❑ Blood in urine
- ❑ Genital discharge
- ❑ Kidney stones
- ❑ Sinus problems
- ❑ Dry mouth
- ❑ Post nasal drip
- ❑ Hearing loss
- ❑ Runny nose
- ❑ Headache
- ❑ Joint ache
- ❑ Migraines
- ❑ Paralysis fever
- ❑ Cough
- ❑ Emphysema
- ❑ Bronchitis
- ❑ COPD
- ❑ Shortness of breath
- ❑ Asthma
- ❑ Other:

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Social History: (CIRCLE all that apply)

Smoking:

- Never smoked
- Current smoker:
  What do you smoke? Cigarettes / Cigar / Other:
  How much do you currently smoke? _____ cig / pack per day for _____ years
- Former smoker:
  When did you stop smoking? _____
  What did you used to smoke? Cigarettes / Cigar / Other:
  How much did you used to smoke: _____ cig / pack per day _____ years

Alcohol:

- Never
- Current- Type: Beer / Spirits / Wine Amount: Occasionally / ____ drinks per day / ____ drinks per week
- Former- Type: Beer / Spirits / Wine Amount: Occasionally / ____ drinks per day / ____ drinks per week

Driving: Do you drive? Yes / No

Medications:

Pharmacy

- Name: _____
- Address: _____
- Phone number: _____

Eye Drops

Name of Drop (or reason why you take it)	Strength of drop (%)	How many times a day do you take it?
1.		
2.		
3.		
4.		
5.		

Systemic Medications (pills or injections)

Name of Medicine (or reason why you take it)	Name of Medicine (or reason why you take it)
1.	13.
2.	14.
3.	15.
4.	16.
5.	17.
6.	18.
7.	19.
8.	20.
9.	21.
10.	22.
11.	23.
12.	24.

Vitamins, Herbs, and Other supplements: None / Yes – Please list all that you take:

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Past Surgical History: Please list any non-eye surgeries (including dates).

Eye surgeries:

Cataract:	No / Yes:
Retinal:	No / Yes:
Eye injections:	No / Yes:
Glaucoma:	No / Yes:
Corneal:	No / Yes:
Vision correction:	No / Yes:
Other:	

Other surgeries/procedures:

Allergies: (CIRCLE all that apply)

No / Yes: Medications

Penicillin – Reaction:_____
Sulfa – Reaction:_____
Other (with reactions):

No / Yes: Latex Allergy: Reaction: _____
No / Yes: Iodine Allergy: Reaction: _____