

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:

Other:

- ☐ Cardiac valvular disease
- ☐ Sarcoidosis
- ☐ Sleep apnea
- ☐ Hepatitis/liver disease
- ☐ Colon polyps
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Prostate problems
- ☐ Kidney failure

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:

- ☐ 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?

- | | | |
|---|--|--|
| <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Joint ache |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Genital ulcers | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Paralysis fever |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Genital discharge | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Skin disease | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Post nasal drip | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Runny nose | <input type="checkbox"/> 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:**GO TO NEXT PAGE**

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: _____