

Date _____

Reviewed by _____
Date reviewed _____

Patient Name _____

Email: _____

Date of Birth _____

Optometrist? Name: _____

Medical Doctor's Name _____

Other? Name: _____

Were you referred here by:

What is your usual line of work? _____

Medical Doctor? Name: _____

Active Inactive/retired

Chief Complaint/HPI

Reason for Visit* _____

Severity* _____

Symptoms* _____

Decreased Vision Dry Eye Glaucoma

Which Eye* _____

Diabetic Other _____

Started* _____

How Long* _____

Additional Comments: _____

Pharmacy Name _____

Address _____ Phone _____

Past Ocular/Medical History

Allergies: _____

Past Eye History* _____

Past Eye Surgeries* _____

Current Eye Medications* _____

Past Medical History*

Diabetic: Type I or Type II

Other _____

Past Surgeries* _____

Current Medications* _____

Family Eye and Health History

Description	Relation	Status	Approx.Age	Comments
<input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
<input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Other _____		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
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Social History

Smoking Status _____

Other/Explanation _____

Alcohol yes no If yes: How much? _____

Drugs yes no Drugs Used _____

How Much? _____

How Long? _____

When Quit? _____

Please complete both sides of this form.

Patient Name _____

Date of Birth _____

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Review of Systems

EYES*

- Previous Surgery Yes No
Contact Lens Yes No
Pain Yes No
Double Vision Yes No
Glaucoma Yes No
Cataracts Yes No
Macular Degeneration Yes No
Dry Eyes Yes No
Flashes Yes No
Floaters Yes No

EARS, NOSE, and THROAT*

- Hard of hearing Yes No
Ringing in Ears Yes No
Vertigo Yes No

CARDIOVASCULAR*

- Chest pain Yes No
Dizziness Yes No
Fainting Spells Yes No
Shortness of Breath Yes No
Irregular Heartbeat Yes No
Difficulty Lying Flat Yes No

CONSTITUTIONAL*

- Fatigue/Weakness Yes No
Fever Yes No
Weight Gain/Loss Yes No

RESPIRATORY*

- Cough Yes No
Congestion Yes No
Wheezing Yes No
Asthma Yes No
Sleep Apnea Yes No
Past Anesthesia Problems Yes No

GASTROINTESTINAL*

- Heartburn Yes No
Nausea/Vomiting Yes No
Jaundice/Hepatitis Yes No

GENITO-URINARY*

- Pain/Difficulty Yes No
Blood in Urine Yes No
History of Kidney Stones Yes No
Pregnant/Planning On Yes No
History of STD's Yes No

PSYCHIATRIC*

- Anxiety/Depression Yes No
Mood Swings Yes No
Difficulty Sleeping Yes No
Claustrophobia Yes No

ENDOCRINE*

- Increased Thirst Yes No
Increased Hunger Yes No
Increased Urination Yes No
Increased Sweating Yes No
Fingernail Changes Yes No

BLOOD/LYMPH NODES*

- Easy Bruising Yes No
No Gums Bleed Easily Yes No
Prolong Bleeding Yes No
Heavy Aspirin Use Yes No
Bleeding prob w/prev 5x Yes No
Hx Blood Transfusions Yes No

MUSCULOSKELETAL*

- Stiffness Yes No
Arthritis Yes No
Joint Pain/Swelling Yes No

SKIN*

- Rash/Sores Yes No
Lesions Yes No
Hives/Eczema Yes No

NEUROLOGICAL*

- Seizures Yes No
Weakness/Paralysis Yes No
Numbness Yes No
Tremors Yes No
Headaches Yes No

IMMUNOLOGIC*

- Hives Yes No
Itching Yes No
Runny Nose Yes No
Sinus Pressure Yes No

Pregnancy Questions

Are you pregnant? Yes No

How Many weeks? _____

Have you been told you have gestational diabetes? _____

Please complete both sides of this form.