Date ______________________

Reviewed by ____________
Date reviewed ____________

Patient Name ________________________________
Date of Birth ________________________________
Height ________ ft/in Weight ________ lb
Medical Doctor's Name ________________________
Were you referred here by:
Medical Doctor? Name: ________________________

Email: ________________________________
Optometrist? Name: ________________________
Other? Name: ________________________
What is your usual line of work? ________________
❒ Active ❒ Inactive/retired

## Chief Complaint/HPI

**Reason for Visit*** ________________________

Symptoms* ________________________

❒ Decreased Vision ❒ Dry Eye ❒ Glaucoma
❒ Diabetic ❒ Other ________________________

Severity* ________________________
Which Eye* ________________________
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 |
|---|---|---|---|---|
| ❒ Cataracts ❒ Glaucoma ❒ High Blood Pressure ❒ Heart Disease ❒ Stroke ❒ Other__________ | | ❒ Alive ❒ Deceased | | |
| ❒ Cataracts ❒ Glaucoma ❒ High Blood Pressure ❒ Heart Disease ❒ Stroke ❒ Other__________ | | ❒ Alive ❒ Deceased | | |
| ❒ Cataracts ❒ Glaucoma ❒ High Blood Pressure ❒ Heart Disease ❒ Stroke ❒ Other__________ | | ❒ Alive ❒ Deceased | | |
| ❒ Cataracts ❒ Glaucoma ❒ High Blood Pressure ❒ Heart Disease ❒ Stroke ❒ Other__________ | | ❒ Alive ❒ Deceased | | |

## 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 ____________________________________

**Please complete both sides of this form.**

## 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
- Gums Bleed Easily ❐ Yes ❐ No
- Prolong Bleeding ❐ Yes ❐ No
- Heavy Aspirin Use ❐ Yes ❐ No
- Bleeding prob w/prev Surg. ❐ 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.**