UNIVERSITY EYE SPECIALISTS

Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Primary Care Provider (PCP): _____ MD/NP/PA	Eye Care Provider (ECP): _____ MD/OD
*Were your **Referred** here today by your:* ☐PCP, ☐ECP or ☐friend, relative, other_____	
What is your usual line of work? _____	☐ Retired? Email: _____
What is the main reason for your visit? _____	

HEALTH HISTORY & PRESENT MEDICAL CONDITIONS

Please circle Yes or No for *present* and *past* conditions and indicate family history (where asked):

Yes	No	Asthma, Bronchitis, Emphysema	Yes	No	Psychiatric Disorder-Please list: _____
Yes	No	High Blood Pressure			_____
Yes	No	Kidney Disease	Yes	No	Nervous Disorder-Please list: _____
Yes	No	Temporal Arteritis			_____
Yes	No	Tuberculosis	Yes	No	Extensive Confinement by Illness or Injury: _____
Yes	No	Diabetes since _____ (year)			_____
Yes	No	Insulin (number of years _____)	Yes	No	Permanent Defect from Illness, Disease, or Injury
Yes	No	Sickle Cell Anemia			(Type _____)
Yes	No	Migraines	Yes	No	Are you pregnant? If so, how many weeks: _____
Yes	No	Congestive Heart Failure	Yes	No	Have you been told you have gestational diabetes?
Yes	No	Carotid Artery Disease	Yes	No	Other Diagnosed Health Problem _____
Yes	No	HIV			_____
Yes	No	Rheumatoid Arthritis	Yes	No	Iritis or Uveitis: Right /Left/ Both
Yes	No	Lupus/Other Autoimmune Disease:	Yes	No	Retina Disease: Right/Left/Both
Yes	No	Type: _____			Type: _____
Yes	No	Use of Plaquenil since _____ (year)	Yes	No	Crossed Eyes
Yes	No	Head or Spinal Injuries _____ (year)	Yes	No	Lens Implant: Right/Left/Both
			Yes	No	Eye Injury: Right/Left/Both _____ (year)
Yes	No	Glaucoma ☐ Family History?	Yes	No	Macular Degeneration ☐ Family History?
Yes	No	Cataracts ☐ Family History?	Yes	No	Diabetes Type I/Type II ☐ Family History?
Yes	No	Cornea Disease ☐ Family History?	Yes	No	Diabetic Retinopathy ☐ Family History?
Yes	No	Retinitis Pigmentosa ☐ Family History?	Yes	No	Heart Attack ☐ Family History?
Yes	No	Retinal Detachment ☐ Family History?	Yes	No	Stroke ☐ Family History?
Yes	No	Other Eye Disorder: ☐ Family History?	Yes	No	Other Health Problems: ☐ Family History?
		_____			_____

SOCIAL HISTORY

Yes	No	Do you drive? If YES, do you have **any** visual difficulty driving? (i.e. Reading signs, starbursts or halos) Yes No
Yes	No	Do you exercise regularly?
Yes	No	Do you drink alcohol? If YES, for how many years? _____ If NO, how many years since last use? _____ ☐ Never
Yes	No	Do you smoke? If YES, for how many years? _____ If NO, how many years since last use? _____ ☐ Never
Yes	No	Do you use drugs? If YES, for how many years? _____ If NO, how many years since last use? _____ ☐ Never
Yes	No	Do you have an Advanced Directive or a Living Will?

EDUCATION (circle highest obtained): High School Graduate College Graduate Post-Graduate Degree Other: _____

SURGICAL HISTORY

Please list ALL surgeries you have undergone and the date. Also, list the surgeon for any eye surgeries.

SURGERIES:	Date:	EYE SURGERIES:	Date:
_____	_____	_____	_____
_____	_____	_____	Date:_____
_____	_____	_____	Date:_____
_____	_____	_____	Date:_____
_____	_____	_____	Date:_____
_____	_____	_____	Date:_____
_____	_____	_____	Date:_____
_____	_____	_____	Date: _____

Patient Name: _____ **Date of Birth:** _____

REVIEW OF SYSTEMS

EYES			RESPIRATORY			BLOOD/LYMPH NODES		
Contact Lens Use	Yes	No	Cough	Yes	No	Easy Bruising	Yes	No
Eye Pain	Yes	No	Congestion	Yes	No	Gums Bleed Easily	Yes	No
Double Vision	Yes	No	Wheezing	Yes	No	Prolonged Bleeding	Yes	No
Dry Eyes	Yes	No	Asthma	Yes	No	Frequent Aspirin Use	Yes	No
Flashes	Yes	No	Sleep Apnea	Yes	No	Bleeding Problems with	Yes	No
Floaters	Yes	No	Past Anesthesia Problems	Yes	No	Previous Surgery		
Glare or Starbursts	Yes	No	**GASTROINTESTINAL**			History of Blood Transfusions	Yes	No
Eye Irritation	Yes	No	Heartburn	Yes	No	**MUSCULOSKELETAL**		
Blurred Vision	Yes	No	Nausea/Vomiting	Yes	No	Stiffness	Yes	No
EARS/NOSE/THROAT			Jaundice/Hepatitis	Yes	No	Arthritis	Yes	No
Hard of Hearing	Yes	No	Ulcer/Heartburn	Yes	No	Joint Pain/Swelling	Yes	No
Ringing in Ears	Yes	No	**GENITO-URINARY**			**SKIN**		
Vertigo	Yes	No	Pain/Difficulty Urinating	Yes	No	Rash/Sores	Yes	No
Dry Mouth	Yes	No	Blood in Urine	Yes	No	Lesions	Yes	No
Pulsatile Tinnitus	Yes	No	History of Kidney Stones	Yes	No	Hives/Eczema	Yes	No
Increased Dental Cavities	Yes	No	History of STDs	Yes	No	**NEUROLOGICAL**		
			Pregnant/Planning on	Yes	No	Seizures	Yes	No
CARDIOVASCULAR			**PSYCHIATRIC**			Weakness/Paralysis	Yes	No
Chest Pain	Yes	No	Anxiety/Depression	Yes	No	Numbness	Yes	No
Dizziness	Yes	No	Mood Swings	Yes	No	Tremors	Yes	No
Fainting	Yes	No	Difficulty Sleeping	Yes	No	Headaches	Yes	No
Shortness of Breath	Yes	No	Claustrophobia	Yes	No	**IMMUNOLOGIC**		
Irregular Heartbeat	Yes	No	**ENDOCRINE**			Hives	Yes	No
Difficulty Lying Flat	Yes	Yes	Increased/Decreased Thirst	Yes	No	Itching	Yes	No
CONSTITUTIONAL			Increased/Decreased Hunger	No	No	Runny Nose/Seasonal Allergy	Yes	No
Fatigue/Weakness	Yes	No	Increased/Decreased Urination	Yes	No	Sinus Pressure	Yes	No
Fever	Yes	No	Increased/Decreased Sweating	Yes	No	Anaphylaxis	Yes	No
Weight Gain/Loss	Yes	No	Fingernail Changes	Yes	No			

Please list ALL medications you currently take:

Medication:	**Dosage:**	**Medication:**	**Dosage:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Eye Medication:	**Freq & eye**	**Eye Medication:**	**Freq & eye**
_____	R / L / B	_____	R / L / B
_____	R / L / B	_____	R / L / B
_____	R / L / B	_____	R / L / B
_____	R / L / B	_____	R / L / B

Medication ALLERGIES	Reaction Type
Medication Allergy:	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature **Date**