

Name: _____ Date of Birth: _____

PCP: _____ Specialist: _____

Eyes Conditions

- Retinal Detachment R / L
- Diabetic Retinopathy R / L
- Corneal Transplant R / L
- Macular Degeneration R / L
- Glaucoma R / L
- Cataract R / L
- Iritis / Uveitis R / L

Eye Procedures / Injuries

- Cataract Surgery R / L Date: _____
- Glaucoma Surgery R / L Date: _____
- Lasik R / L Date: _____
- PRK R / L Date: _____
- RK R / L Date: _____
- Other Procedures/Injuries: _____

Eye Medications/Drops (indicate frequency and eye)

Prescription Medications/Vitamins (with dosage)

check here if medication list attached

Allergies and Reaction: _____

Medical History

- | | |
|--|--|
| <input type="checkbox"/> Diabetes (date of onset) _____ | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma / COPD |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> TB |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> MRSA (date of onset) _____ | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Pacemaker / Defibrillator (date of onset) _____ | <input type="checkbox"/> Other: _____ |

Past Major Surgical Procedures / Dates

Family History

- | | |
|---|--|
| <input type="checkbox"/> Corneal Transplant | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Congenital Defects | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Loss of Vision in youth |

Personal / Social

Marital Status: _____ Occupation: _____ Driving: yes no

Current Smoker: yes no Packs a day: _____ Years: _____ If Past Smoker, Year Quit: _____

Alcohol Use: rare / occasional weekly daily

Recreational Drugs: yes no Type: _____

REVIEW OF SYSTEMS – PLEASE CIRCLE ALL THAT APPLY

- GENERAL:** NONE / FEVER / WEIGHT LOSS / NO APPETITE / FATIGUE / VERY THIRSTY
OTHER: _____
- EYES:** NONE / BLURRING / TEARING / BURNING / ITCHING / PAIN
OTHER: _____
- EARS/NOSE/THROAT:** NONE / POOR HEARING / SINUS PROBLEMS
OTHER: _____
- HEART:** NONE / HIGH BLOOD PRESSURE / LOW BLOOD PRESSURE / SLOW HEARTBEAT
IRREGULAR HEARTBEAT / HEART FAILURE
OTHER: _____
- LUNGS:** NONE / ASTHMA / EMPHYSEMA / BRONCHITIS / SLEEP APNEA / COPD
OTHER: _____
- ABDOMINAL:** NONE / DIARRHEA / CONSTIPATION / ULCER / GI BLEEDING
OTHER: _____
- GENITAL/URINARY:** NONE / KIDNEY STONES / INFECTION / IMPOTENCE / FREQUENT URINATION
OTHER: _____
- SKIN/JOINTS:** NONE / RASHES / BREAST LUMPS / COLD HANDS AND FEET
EASILY BRUISED / ARTHRITIS
OTHER: _____
- NEUROLOGICAL:** NONE / MIGRAINES / HEADACHES / STROKE / ALZHEIMER'S
OTHER: _____
- BLOOD:** NONE / ANEMIA / PRIOR TRANSFUSION / HIV VIRUS / EASILY BLEED
OTHER: _____
- PSYCHIATRIC:** NONE / DEPRESSION / BIPOLAR / ANXIETY / POOR MEMORY
OTHER: _____
- ENDOCRINE:** NONE / LOW THYROID / HIGH THYROID / INSULIN DIABETES
NON-INSULIN DIABETES
OTHER: _____