NAME: _____ **DOB:** _____

PAST EYE CONDITIONS & SURGERIES: [None ☐] _____
_____
_____

OTHER HEALTH CONDITIONS: [None ☐] _____
_____
_____

PAST NON-EYE RELATED SURGERIES (Surgery type, affected body part, and year): [None ☐]
_____
_____
_____

DRUG <u>ALLERGIES</u>/REACTIONS: [None ☐] _____
_____
_____

CURRENT MEDICATIONS (all medications, not just eye-related):

☐ **Check here if you are attaching a list instead**

MEDICATION NAME	STRENGTH	DOSAGE/FREQUENCY	ROUTE OF ADMINISTRATION							
			Oral	Eyedrop	Topical	Nasal	Inhaler	Injection	Infusion	Suppository

DIABETIC PATIENTS: MOST RECENT A1C results: _____ Date: _____

SOCIAL HISTORY: <u>1) SMOKING:</u> ☐ Every day ☐ Sometimes ☐ Former smoker ☐ Never

<u>2) ALCOHOL:</u> ☐ Yes ☐ No If Yes, what types & how much/how often: _____
_____

<u>3) DRUGS:</u> ☐ Yes ☐ No If Yes, what types & how much/how often: _____
☐ Past User _____

PLEASE COMPLETE <u>BOTH</u> SIDES!!! ►►►►►►►►►►►►

FAMILY HISTORY: (Please check all that apply & circle relationship) ☐ **No history** ☐ **Unknown** ☐ **Decline to answer**

☐ **Arthritis**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Blindness**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Cancer**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Diabetes**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Glaucoma**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Heart Disease**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **High Blood Pressure**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Kidney Disease**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Lazy Eye**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Macular Degeneration**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Retinal Disease**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Stroke**	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent
☐ **Other:**_____	Mother	Father	Sibling	Child	Aunt	Uncle	Maternal Grandparent	Paternal Grandparent

REVIEW OF SYSTEMS

(Symptoms that you are *currently experiencing*- please check yes or no)

EYES

Previous surgery	☐ Yes	☐ No
Contact Lens wearer	☐ 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

EAR, NOSE, & 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

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 Stone(s)	☐ Yes	☐ No
History of STDs	☐ Yes	☐ No

PSYCHIATRIC

Anxiety/Depression	☐ Yes	☐ No
Mood Swings	☐ Yes	☐ No
Difficulty Sleeping	☐ 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
Prolonged Bleeding	☐ Yes	☐ No
Heavy Aspirin Use	☐ Yes	☐ No

MUSCULOSKELETAL

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

SKIN

Rashes/Sores	☐ Yes	☐ No
Lesions	☐ Yes	☐ No
Hives/Eczema	☐ Yes	☐ No

NEUROLOGICAL

Seizures	☐ Yes	☐ No
Weakness/Paralysis	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

IMMUNOLOGIC

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