

Patient:		Date
Address		DOB
		Age
Occupation		Phone H
Referral		W
		Last Exam
Medical Doctor:	Last medical exam:	Insurance

Medical History

List Medications you are taking

Date _____	Date _____	Date _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to medications ? Y N

Are you pregnant or nursing ? Y N

Do you wear contact lenses ? Y N

Type of contact lenses: Gas Perm / Soft

The enclosed medical information will be held in strict confidence and not released without patient’s consent

Family History

Disease	Relationship	Social History	Y	N
<input type="checkbox"/> Blindness	_____	Do you smoke ?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cataract	_____	Do you drink alcohol ?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Glaucoma	_____	Do you drive ?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Macular Degeneration	_____	Do you have difficulty driving ?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Retinal Detachment	_____			
<input type="checkbox"/> Diabetes	_____			
<input type="checkbox"/> Other	_____			

Review of Systems

Do you currently or have you recently had any problems in the following areas?

System	Y	N	?		Y	N	?
Constitutional				Ear, Nose & Throat			
Fever, weight loss/ gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Dry mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Respiratory			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Vascular / Cardiovascular			
Eyes				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of vision loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness / sandy gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastro-intestinal			
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic diarrhea or constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching or burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones / Joints / Muscles			
Excess tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare / light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infection of eye or lids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic / Hematological			
Sties or chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes or floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid / other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary				Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals/ kidney/ bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

If you answered yes to any of the above, please explain:

Changes _____ Patient Initial: _____ Date: _____ Dr. Initial _____

Changes _____ Patient Initial: _____ Date: _____ Dr. Initial _____

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Changes _____ Patient Initial: _____ Date: _____ Dr. Initial _____

Changes _____ Patient Initial: _____ Date: _____ Dr. Initial _____

Changes _____ Patient Initial: _____ Date: _____ Dr. Initial _____