

Name: _____ Age: _____ DOB: _____

Date of Last Eye Exam _____ Previous Eye Doctor _____
Date of Last Physical Exam _____ Medical Doctor: _____

What are your hobbies? _____

Do you use tobacco products? No Yes: type/amount/how long? _____

Do you drink alcohol? No Yes: type/amount/how long? _____

Do you use illegal drugs? No Yes: type/amount/how long? _____

Are you allergic to any medications? No Yes: _____

List your current medications (including over the counter, vitamins, home remedies).

List major surgeries and hospitalizations. _____

Do you wear glasses or contact lenses? No Yes: _____

Please check if you or any members of your family have the following:

Self

Family

No	Yes	Date of Diagnosis (self)		
<input type="checkbox"/>	<input type="checkbox"/>	_____	Lazy or crossed eyes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal disease	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degeneration	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart disease	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid	<input type="checkbox"/>

Office use only: Updated: _____ _____ _____ _____
--

Do you currently, or have you ever had any problems in the following areas:

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Constitutional: <input type="checkbox"/> Fever, <input type="checkbox"/> Weight loss/gain
<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, Mouth, Throat: <input type="checkbox"/> Sinus Congestion/Infection
<input type="checkbox"/>	<input type="checkbox"/>	Neurological: <input type="checkbox"/> Headaches/Migraines, <input type="checkbox"/> Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory: <input type="checkbox"/> Asthma, <input type="checkbox"/> Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Eyes: <input type="checkbox"/> Blurred Vision, <input type="checkbox"/> Double Vision, <input type="checkbox"/> Dryness, <input type="checkbox"/> Injury, <input type="checkbox"/> Eye Pain, <input type="checkbox"/> Other
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular: <input type="checkbox"/> Heart Disease, <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal: <input type="checkbox"/> Diarrhea/Constipation, <input type="checkbox"/> IBS
<input type="checkbox"/>	<input type="checkbox"/>	Blood: <input type="checkbox"/> Bleeding problems, <input type="checkbox"/> Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Bones/Muscles: <input type="checkbox"/> Rheumatoid Arthritis, <input type="checkbox"/> Joint pain
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary: <input type="checkbox"/> Genitals/Kidney/Bladder
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine: <input type="checkbox"/> Thyroid/other glands, <input type="checkbox"/> Diabetes (type I or II?)
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Currently pregnant and/or nursing
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric
<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	Other: Please list any other health problems _____

Patient Signature: _____