Acct#_____

Name:_____ **DOB**_____ **Date**_____

What brings you in today?_____

Please list any allergies or specify "NONE": _____

Eye History ☐ **none**
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Lazy Eye
- ☐ Retinal Problems
- ☐ _____

Eye Surgeries ☐ **none**
- ☐ Cataract
- ☐ LASIK / PRK / RK
- ☐ Glaucoma
- ☐ Retina surgery
- ☐ _____

Eye Medications ☐ **none**
- ☐ Artificial tears
- ☐ Allergy drops
- ☐ _____
- ☐ _____

Medical History ☐ **none**
- ☐ Asthma
- ☐ COPD
- ☐ CVA / Stroke
- ☐ Diabetes Type I
- ☐ Diabetes Type 2
- ☐ Grave's Disease
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ _____
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Lupus
- ☐ Migraine
- ☐ Prostate
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Sleep Apnea
- ☐ Thyroid
- ☐ _____
- ☐ _____

Past Surgeries ☐ **none**
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Smoking
- ☐ current
- ☐ former
- ☐ never

Alcohol
- ☐ daily
- ☐ occasionally
- ☐ never

Recreational Drugs Y / N

Family History ☐ **none**
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Thyroid
- ☐ _____

Please check if you have any of the following ☐ **none**
- ☐ Contact lens
- ☐ Pain
- ☐ Double Vision
- ☐ Glare, light scatter
- ☐ Burning, watering

_____
- ☐ Hard of hearing
- ☐ Ringing in ears
- ☐ Vertigo

_____
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Shortness of breath
- ☐ Irregular Heartbeat
- ☐ Difficulty lying flat

_____
- ☐ Fatigue / Weakness
- ☐ Fever
- ☐ Weight Gain / Loss
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma

_____
- ☐ Heartburn
- ☐ Nausea / Vomiting
- ☐ Jaundice / Hepatitis

_____
- ☐ Difficulty with urination
- ☐ Blood in urine
- ☐ Kidney Stones
- ☐ History of STD's

_____
- ☐ Anxiety / Depression
- ☐ Mood swings
- ☐ Difficulty sleeping

_____
- ☐ Increased thirst
- ☐ Increased hunger
- ☐ Increased urination
- ☐ Increased sweating
- ☐ Fingernail changes
- ☐ Easy bruising
- ☐ Gums bleed easily
- ☐ Prolonged bleeding
- ☐ Heavy Aspirin use

_____
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint pain / Swelling

_____
- ☐ Rash / sores
- ☐ Lesions
- ☐ Hives / Eczema

_____
- ☐ Seizures
- ☐ Weakness / Paralysis
- ☐ Numbness
- ☐ Tremors

_____
- ☐ Hives
- ☐ Itching
- ☐ Runny nose
- ☐ Sinus pressure

Current Medications ☐ **none**

please include strength and dosage

_____

_____

_____

_____

_____

_____

_____

_____

_____