

Name _____ Date of birth _____ Today's Date _____

Medical History

Primary Care Physician: _____

List any medications you take: _____

List any allergies to medications: _____

List eye infections, eye injuries, eye surgeries, or other major injuries, surgeries, and/or hospitalizations you have had: _____

Social History

Do you smoke: Y N Do you use smokeless tobacco: Y N Quantity and for how long: _____

Do you drink: Y N Quantity and for how long: _____

Do you use illegal drugs: Y N Type, Quantity, and for how long: _____

Have you been exposed or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Please circle any areas that you currently or have ever had problems out of the ordinary

Eyes	Ears, Nose, Mouth, Throat	Endocrine
Crossed Eyes/ Lazy eye	Allergies/ Hay fever	Thyroid /Other glands
Drooping eyelid	Sinus Problem	Diabetes
Loss of Vision/ Loss of Side Vision	Ear Infections	Genitourinary
Distorted Vision/ Halos	Chronic Cough	Genitals
Glare/ Light Sensitivity	Dry Throat/ Mouth	Kidney/ Bladder
Double Vision	Respiratory	Pregnant/ nursing
Dryness/ Itching/ Burning	Asthma	Psychiatric
Sandy or Gritty Feeling	Breathing Problems	Immune System/ Cancer
Excess Tearing/ Watering	Chronic Bronchitis	Lymphatic/ Hematologic
Retinal disease	Emphysema	Anemia
Glaucoma	Vascular/cardiovascular	Bleeding Problems
Cataracts	Heart Disease	Bones, Joints, Hematologic
Chronic Infection of Eye or Lid	Heart pain	Rheumatoid Arthritis
Sties	High Blood Pressure	Muscle Pain
Flashes/ Floater in Vision	Vascular Disease	Joint Pain
Tired Eyes	Neurological	Integumentary (Skin)
Night Vision/ Driving Problems	Headaches	Constitutional
Computer Vision Problems	Migraines	Fever
Reading/ Distance Vision	Seizures	Weight Loss/Gain

Family History

Please note any family history (mother, father, maternal/paternal grandparents, siblings, children, living or deceased)

	Relationship to you			Relationship to you	
Lazy eye	N	Y	Diabetes	N	Y
Blindness	N	Y	Cancer	N	Y
Crossed Eyes	N	Y	Heart Disease	N	Y
Glaucoma	N	Y	High Blood Pressure	N	Y
Macular Degeneration	N	Y	Immune Deficiencies	N	Y
Retinal detachment/Disease	N	Y	Lupus	N	Y
Thyroid Disease	N	Y	Other _____	N	Y

-----Staff info below this line-----

CC: medical from above _____

HPI: location, quality, severity, duration, timing, context, modifying factors, associated symptoms (4+) on CC

BP: IOP: Periphery: Distance: Near: