Patient History

Eye Diseases — None Apply ◯
- Glaucoma ◯ Yes ◯No
- Macular Degeneration ◯ Yes ◯No
- Retinal Detachment ◯ Yes ◯No

Constitutional Symptoms — None Apply ◯
- Fever ◯ Yes ◯No
- Fatigue ◯ Yes ◯No
- Other ◯ Yes ◯No

Ear, Nose, Throat, Mouth — None Apply ◯
- Hearing Loss ◯ Yes ◯No
- Sinus Disorders ◯ Yes ◯No
- Other ◯ Yes ◯No

Cardiovascular — None Apply ◯
- Atrial Fibrillation ◯ Yes ◯No
- Heart Disease ◯ Yes ◯No
- Hypertension ◯ Yes ◯No
- Other ◯ Yes ◯No

Respiratory — None Apply ◯
- Asthma ◯ Yes ◯No
- Emphysema/COPD ◯ Yes ◯No
- Shortness of breath ◯ Yes ◯No
- Other ◯ Yes ◯No

Gastrointestinal — None Apply ◯
- Intestinal Conditions ◯ Yes ◯No
- Other ◯ Yes ◯No

Urinary — None Apply ◯
- Flomax Use ◯ Yes ◯No
- Kidney Disease ◯ Yes ◯No
- Urinary Conditions/Symptoms ◯ Yes ◯No
- Other ◯ Yes ◯No

Musculoskeletal — None Apply ◯
- Arthritis ◯ Yes ◯No
- Muscle/Joint/Back Pain ◯ Yes ◯No

Skin — None Apply ◯
- Herpes ◯ Yes ◯No
- Rash/itching ◯ Yes ◯No
- Rosacea ◯ Yes ◯No
- Shingles ◯ Yes ◯No
- Skin Cancer ◯ Yes ◯No
- Other ◯ Yes ◯No

Neurological — None Apply ◯
- Multiple Sclerosis ◯ Yes ◯No
- Frequent Headaches ◯ Yes ◯No
- Convulsions/Seizure ◯ Yes ◯No
- Other ◯ Yes ◯No

Psychiatric — None Apply ◯
- Memory Loss ◯ Yes ◯No
- Depression ◯ Yes ◯No
- Other ◯ Yes ◯No

Endocrine — None Apply ◯
- Diabetes ◯ Yes ◯No
- Thyroid Disease ◯ Yes ◯No
- Other ◯ Yes ◯No

Blood — None Apply ◯
- Anemia ◯ Yes ◯No
- Cholesterol ◯ Yes ◯No
- Other ◯ Yes ◯No

Allergic/Immunologic — None Apply ◯
- Seasonal Allergies ◯ Yes ◯No
- Lupus ◯ Yes ◯No
- Other ◯ Yes ◯No

- Pregnant ◯ Yes ◯No
- Nursing ◯ Yes ◯No

Please list your current medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medication Allergies:

_____

_____

Other Conditions: _____

Past eye surgeries or trauma: _____

Family History

No Known Family History ◯

Eye Disease

			Relationship to Patient
Amblyopia (Lazy Eye)	◯ Yes	◯No	_____
Blindness	◯ Yes	◯No	_____
Cataract(s)	◯ Yes	◯No	_____
Color Blindness	◯ Yes	◯No	_____
Eye Tumors	◯ Yes	◯No	_____
Glaucoma	◯ Yes	◯No	_____
Glaucoma Suspect	◯ Yes	◯No	_____
Macular Degeneration	◯ Yes	◯No	_____
Retinal Detachment	◯ Yes	◯No	_____
Strabismus (Eye Turn)	◯ Yes	◯No	_____
Other Eye Conditions	◯ Yes	◯No	_____

Systemic Diseases

			Relationship to Patient
Arthritis	◯ Yes	◯No	_____
Cancer	◯ Yes	◯No	_____
Diabetes	◯ Yes	◯No	_____
Heart Disease	◯ Yes	◯No	_____
High Blood Pressure	◯ Yes	◯No	_____
Kidney Disease	◯ Yes	◯No	_____
Lupus	◯ Yes	◯No	_____
Stroke	◯ Yes	◯No	_____
Thyroid Disease	◯ Yes	◯No	_____
Other Diseases	◯ Yes	◯No	_____

Current Occupation: _____ Hobbies: _____

Do you smoke? ◯ Yes ◯No ◯ Occasional ◯ ½ pack per day ◯ 1 pack per day ◯ 1+ pack per day

Past smoker? ◯ Yes ◯No When did you quit? _____

Last Name: _____ First Name: _____ Date: _____