

## Your Information

1. What is your name?: \_\_\_\_\_ Today's date: \_\_\_\_\_

## Medical History

2. Primary care doctor: \_\_\_\_\_ Tel: \_\_\_\_\_

3. Do you now, or have you ever had:

a. Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diagnosis date: _____
Treatment: diet control <input type="checkbox"/>	oral agents <input type="checkbox"/>	insulin <input type="checkbox"/>	other <input type="checkbox"/>
Medical complication: kidney <input type="checkbox"/>	vascular <input type="checkbox"/>	eye <input type="checkbox"/>	other <input type="checkbox"/>
b. Heart attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Angina or chest pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Heart failure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Irregular or rapid heart beat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Cardiac pacemaker inserted	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
c. High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
d. Stroke or TIA	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
e. Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
f. Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Emphysema and/or bronchitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Pneumonia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
g. Liver disease or jaundice	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
h. Stomach or duodenal ulcer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
i. Kidney stones / other kidney diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
j. Arthritis: rheumatoid <input type="checkbox"/>	osteo <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
k. Cancer or tumor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Type: _____			
Treatment: _____			
l. Thyroid disease: underactive <input type="checkbox"/>	overactive <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Treatment: _____			
m. Migraine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
n. Blood clot in legs	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
o. Bleeding disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
p. Transfusions of blood or plasma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
q. HIV positive, AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
r. Other medical problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Please describe: _____			

4. Are you allergic to any medications or foods? . . . . . Yes  No  \_\_\_\_\_  
If yes, please describe substance(s), with type of reaction: \_\_\_\_\_

## Medications

5. Please list all medications you are using at present in the spaces provided below:

Eye medication(s)				All other medication(s)		
Name	Dose	Frequency	Eye	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**Eye Care History**

6. Eye doctors seen: \_\_\_\_\_  
 Have you ever had any eye injuries? . . . . . Yes  No   
 If yes, please describe injuries and dates: \_\_\_\_\_
7. Have you ever had any previous eye surgery or laser treatment? Yes  No   
 If yes, please give name of operations and dates: \_\_\_\_\_
8. What other operations have you had? Please give types and dates: \_\_\_\_\_

**Systems Review**

9. Are you **currently** having problems with any of the following. Please complete and give details:
- a. Unexplained weight gain or loss greater than 10 lbs . . . . . Yes  No  \_\_\_\_\_
  - b. Fever, chills, night sweats . . . . . Yes  No  \_\_\_\_\_
  - c. Decreased vision, eye pain, double vision . . . . . Yes  No  \_\_\_\_\_
  - d. Decreased hearing, ringing in ears . . . . . Yes  No  \_\_\_\_\_
  - e. Nasal congestion, nose bleeds, sinus congestion . . . . . Yes  No  \_\_\_\_\_
  - f. Hoarse voice, sore throat . . . . . Yes  No  \_\_\_\_\_
  - g. Chest pains or heaviness, shortness of breath, leg pain  
 when walking, ankle swelling, irregular heartbeat . . . . . Yes  No  \_\_\_\_\_
  - h. Cough, wheezing, coughing up blood or sputum . . . . . Yes  No  \_\_\_\_\_
  - i. Heartburn, nausea, stomach pain, diarrhea, constipation . Yes  No  \_\_\_\_\_
  - j. Problems with kidneys, urination, bladder . . . . . Yes  No  \_\_\_\_\_
  - k. Skin rashes or lesions, breast lumps . . . . . Yes  No  \_\_\_\_\_
  - l. Headaches, dizziness, muscle weakness . . . . . Yes  No  \_\_\_\_\_
  - m. Joint Pain, stiffness, swelling . . . . . Yes  No  \_\_\_\_\_
  - n. Depression, nervousness / anxiety . . . . . Yes  No  \_\_\_\_\_
  - o. Lymph node swelling, infections . . . . . Yes  No  \_\_\_\_\_
  - p. Itching, sneezing / allergy symptoms . . . . . Yes  No  \_\_\_\_\_

**Social and Family History**

10. a. Are you a smoker? Yes  No  cigarettes per day: \_\_\_\_\_ When did you stop? \_\_\_\_\_  
 b. Alcohol use? None  Social  2-3x week  with dinner  other   
 c. Occupation: \_\_\_\_\_ Live alone: Yes  No   
 d. Exercise? None  Occasionally  Weekly  Daily   
 e. Do you drive? . . . . . Yes  No  \_\_\_\_\_
11. Among your blood relatives, is there any history of any of the following? List: mother, father, sister, brother, etc.
- a. Glaucoma . . . . . Yes  No  \_\_\_\_\_
  - b. Cataracts . . . . . Yes  No  \_\_\_\_\_
  - c. "Lazy eye" or muscle imbalance . . . . . Yes  No  \_\_\_\_\_
  - d. Retinal disease or macular disease . . . . . Yes  No  \_\_\_\_\_
  - e. Migraine . . . . . Yes  No  \_\_\_\_\_
  - f. Night blindness/color blindness . . . . . Yes  No  \_\_\_\_\_
  - g. Unexplained vision loss . . . . . Yes  No  \_\_\_\_\_
  - h. Diabetes mellitus . . . . . Yes  No  \_\_\_\_\_
  - i. Tumor or cancer . . . . . Yes  No  \_\_\_\_\_
  - j. High blood pressure . . . . . Yes  No  \_\_\_\_\_
  - k. Heart disease . . . . . Yes  No  \_\_\_\_\_
  - l. Bleeding disorder . . . . . Yes  No  \_\_\_\_\_
12. If applicable, are you pregnant? . . . . . Yes  No  \_\_\_\_\_
13. Interested in Laser Vision Refractive Surgery (LASIK)? . . . . . Yes  No  \_\_\_\_\_

Patient signature: \_\_\_\_\_ Doctor signature: \_\_\_\_\_ Technician signature: \_\_\_\_\_