

Patient Name: _____

Date of Birth: _____ Age: _____

Referring Physician: _____

Primary Care Physician: _____

Date of Last Physical Exam: _____

Date of Last Eye Exam: _____

Review of Systems

What kind of eye problems are you having? Please note which eye and how long.

Eye Pain _____

Loss of Vision _____

Distorted Vision _____

Loss of Side Vision _____

Flashing Lights _____

Floater _____

Trauma to Eyes _____

Other Symptoms _____

Do you have any of these **symptoms**? Please **CIRCLE** all that apply.

- Fever --- Chills --- Weight Changes --- Fatigue --- Chest Pains --- Angina --- Irregular Heart Beat
- Cough --- Shortness of Breath --- Heart Burn --- Nausea --- Vomiting --- Constipation --- Diarrhea
- Blood in Stool --- Frequent Urination --- Blood in Urine --- Muscle Pain --- Joint Pain/Stiffness
- Skin Problems --- Numbness --- Tingling --- Seizures --- Loss of Consciousness --- Headaches
- Heat or Cold Intolerance --- Excessive Thirst --- Bleed or Bruise Easily --- Rashes

Do you have any of these **diseases**? Please **CIRCLE** all that apply.

- High Blood Pressure --- Heart Attack --- Stroke --- Diabetes --- Thyroid Disease --- Anemia
- Psychiatric Disease --- Bowel Disease --- Connective Tissue Disease --- Epilepsy --- Asthma
- Lung Disease --- Kidney Disease --- Other _____

Please list all **allergies** to medications. _____

Have you ever been diagnosed with **cancer**? Please describe. _____

Please list all **major injuries**. _____

Please list all **eye surgeries**. _____

Please list all **other surgeries**. _____

Please list all **medications**. _____

Past Ocular History

Have you ever had (check all that apply):

- _____ Crossed Eyes
- _____ Lazy Eye
- _____ Retinal Detachment
- _____ Cataract
- _____ Diabetic Retinopathy
- _____ Macular Degeneration
- _____ Retinal Tear
- _____ Glaucoma

Family History

Do you have a family history of (check all that apply):

- _____ Cataract
- _____ Glaucoma
- _____ Macular Degeneration
- _____ Retinal Detachment
- _____ Diabetes
- _____ Heart Disease
- _____ High Blood Pressure
- _____ Inherited Eye Disease

Social History

Marital Status (please circle one): Married ----- Divorced ----- Single ----- Widowed

Is someone available to help you when you are ill (Medicare requirement/)? Yes ----- No

Current or past occupation: _____

- | | | | | |
|------------------------------|-----|----|---------------------------|-------------|
| Do you drive? | Yes | No | Any problems? | _____ |
| Do you drink alcohol? | Yes | No | How many drinks per week? | _____ |
| Do you smoke/chew tobacco? | Yes | No | Packs/day | _____ |
| | | | | Years _____ |
| Have you used illegal drugs? | Yes | No | | |

Signature: _____

Date: _____