

## Medical History

Do your vision problems occur at: distance \_\_\_ Near \_\_\_

Do you have headaches? Yes \_\_\_ No \_\_\_ Are your eyes sensitive to sunlight? Yes \_\_\_ No \_\_\_

Do your eyes: Burn \_\_\_ Ache \_\_\_ Tire \_\_\_ Itch \_\_\_ Water \_\_\_ Get Red \_\_\_ Dry Out \_\_\_

Do you work with a computer? Yes \_\_\_ No \_\_\_ If yes, how many hours per day? \_\_\_\_\_

List all medications you are currently taking: (include birth control, hormones, over the counter medications)

\_\_\_\_\_

List all medications that you are allergic to:

\_\_\_\_\_

Are you pregnant or nursing? Yes \_\_\_ No \_\_\_

Have you ever had any injuries to your eyes? \_\_\_\_\_

Have you had any surgeries? Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_

Have you ever had any of the following: Allergies \_\_\_ Asthma \_\_\_ Cataracts \_\_\_ Diabetes \_\_\_ Eye injury \_\_\_

Eye surgery \_\_\_ Glaucoma \_\_\_ Retinal Detachment \_\_\_ Crossed Eyes \_\_\_

Do you wear glasses? Yes \_\_\_ No \_\_\_

Do you wear contact lenses? Yes \_\_\_ No \_\_\_ If yes, how many pair do you have left? \_\_\_\_\_ What kind of solutions do you use? \_\_\_\_\_

Do you wear your lenses over-night? Yes \_\_\_ No \_\_\_

## Family History

Has any family member ever had any of the following: (includes grandparents, parents, brothers, and sisters)

Relationship to you

Asthma \_\_\_

Blindness \_\_\_

Cataracts \_\_\_

Diabetes \_\_\_

Glaucoma \_\_\_

Macular Degeneration \_\_\_

Retinal Detachment \_\_\_

Crossed Eyes \_\_\_

Arthritis \_\_\_

Cancer \_\_\_

Heart Disease \_\_\_

High Blood Pressure \_\_\_

Kidney Disease \_\_\_

Lupus \_\_\_

Thyroid Disease \_\_\_

Other \_\_\_\_\_

## Social History

Do you drive? Yes \_\_\_ No \_\_\_ Any difficulty seeing while you drive? \_\_\_\_\_

Do you use tobacco products? Yes \_\_\_ No \_\_\_ For how long? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_ No \_\_\_ How much/how long? \_\_\_\_\_

Do you use illegal drugs? Yes \_\_\_ No \_\_\_ What type/how long? \_\_\_\_\_

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

\_\_\_\_\_

Your initials

# Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)

System	NO	YES	?	EXPLAIN / MEDICATIONS
<b>INTEGUMENTARY (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>NEUROLOGIC</b>				_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>EYES</b>				_____
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted Vision / Haloes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare / Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes / Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>EARS, NOSE, MOUTH, THROAT</b>				_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>RESPIRATORY</b>				_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>VASCULAR</b>				_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>GASTROINTESTINAL</b>				_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>GENITOURINARY (genitals / kidney / bladder)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>BONES / JOINTS / MUSCLES</b>				_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>LYMPHATIC / HEMATOLOGIC</b>				_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>ENDOCRINE (thyroid / other glands)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>PSYCHIATRIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Doctor's Signature

Review Date