

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Eye Conditions: Have you ever been diagnosed with any of the following conditions?**

- |                                  |  |
|----------------------------------|--|
| Cataract                         | Dry Eye                                |
| Age-related Macular Degeneration | Eye Infection, inflammation or allergy |
| Glaucoma                         | Floaters and/or flashes of light       |
| Diabetes                         | Iritis or Uveitis                      |
| Diabetic Retinopathy             | Retinal defects or degenerations       |

**Please list any additional conditions:**

**Eye Concerns: Are you having any of the following eye concerns?**

- |         |         |           |
|---------|---------|-----------|
| Redness | Itching | Discharge |
| Burning | Tearing |           |

**Please list any additional concerns:**

**Vision Concerns: Are you having any of the following vision concerns?**

- |                |                              |                        |
|----------------|------------------------------|------------------------|
| Blurred vision | Severe sensitivity to lights | Bothersome night glare |
| Eyestrain      | Headache                     | Double vision          |
| Eye Pain       | Poor night vision            | Total loss of vision   |

**Please list any additional vision concerns:**

**Visual and Occupational Function: Please tell us about your current corrective lenses**

Current Occupation: \_\_\_\_\_

**Visual and Occupational Function:**

Do you currently wear?                      CL              Glasses              Neither

**Please answer the following with your latest prescription:**

- |  |     |    |
|--|-----|----|
| Do you have visual difficulty when reading?          | Yes | No |
| Do you have visual difficulty working on a computer? | Yes | No |
| Do you have visual difficulty at distance?           | Yes | No |
| Do you have problems with night vision or glare?     | Yes | No |
| Do you protect your eyes from sun (UV)?              | Yes | No |

**Review of Systems: Do you have current or past problems with?**

Explanation of Problem

<b>General/Constitutional:</b> Sudden weight gain or loss, Chronic fever or fatigue, Loss of Appetite, Cancer	Yes	No
<b>Ears/Nose/Mouth/Throat:</b> Hearing Loss, Sinusitis, Dry Mouth, Laryngitis	Yes	No
<b>Neurological:</b> Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor	Yes	No
<b>Psychiatric:</b> Depression, Anxiety	Yes	No
<b>Cardiovascular:</b> Hypertension, Stroke, Heart Disease, Vascular Disease	Yes	No
<b>Respiratory:</b> Cigarette Smoker, Asthma, Bronchitis, Emphysema, COPD	Yes	No
<b>Gastrointestinal:</b> Crohn's Disease, Colitis, Ulcer	Yes	No
<b>Genitourinary:</b> Kidney Disease, Prostrate Disease/Cancer, STD	Yes	No
<b>Musculoskeletal:</b> Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis	Yes	No
<b>Integumentary (Skin):</b> Eczema, Rosacea, Psoriasis	Yes	No
<b>Endocrine:</b> Diabetes, Thyroid dysfunction, Hormonal dysfunction	Yes	No
<b>Hematologic/Lymphatic:</b> Elevated Cholesterol, Anemia, Large Volume Blood Loss, Leukemia	Yes	No
<b>Allergic/Immunologic:</b> Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus	Yes	No

**Medications and Allergies**

**Do you take any medications? If so please list both prescription and non prescription,** Yes No

**Do you have any allergies? If so please list.** Yes No

**Social History** – This information is kept strictly confidential. However if you prefer to discuss directly with the doctor please leave blank.

Use of Alcohol	Yes	No	Rare	Moderate	Excessive
Use of Tobacco	Yes	No	Previous		Current

**Family Eye and Medical History:**

	Relationship	Relationship
Cataracts	Yes No	Cancer Yes No
Macular Degeneration	Yes No	Diabetes Yes No
Glaucoma	Yes No	Hypertension Yes No
Retinal Detachment/Disease	Yes No	Thyroid Yes No
Blindness	Yes No	Elevated Cholesterol Yes No
Crossed Eyes	Yes No	Heart Disease Yes No

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Initials Upon Review \_\_\_\_\_ Date \_\_\_\_\_