

What is the purpose of today's visit: _____

Date of Last Eye Exam: _____ Date of Last Medical Exam: _____

List Any Major Surgeries: _____

Are you pregnant or nursing: No Yes Currently Taking Medications: No Yes
 Allergies to Medications: No Yes If Yes, please list: _____
 If Yes, please list: _____

Do you currently have or have you had any of the following:

Blurred vision	No	Yes
Loss of vision	No	Yes
Distorted vision	No	Yes
Loss of side vision	No	Yes
Double vision	No	Yes
Red eyes	No	Yes
Dry eyes	No	Yes
Mucous discharge	No	Yes
Sandy or gritty feeling	No	Yes
Excessive tears or watering	No	Yes
Itchy eyes	No	Yes
Foreign body sensation	No	Yes
Eye pain	No	Yes
Chronic eyelid infections	No	Yes
Sties or chalazion	No	Yes
Light flashes or floaters	No	Yes
Tired eyes	No	Yes

Do you currently have or have you had any of the following:

Thyroid disease	No	Yes
Allergies or hay fever	No	Yes
Chronic cough	No	Yes
Dry mouth	No	Yes
Asthma	No	Yes
Chronic bronchitis	No	Yes
Emphysema	No	Yes
Diabetes	No	Yes
Heart disease	No	Yes
High blood pressure	No	Yes
Vascular disease	No	Yes
Diarrhea or constipation	No	Yes
Kidney or bladder disease	No	Yes
Rheumatoid arthritis	No	Yes
Joint pain	No	Yes
Bleeding problems	No	Yes
Depression or anxiety	No	Yes

Please note any family history for the following conditions:

		(relation)
Cataracts	No	Yes _____
Glaucoma	No	Yes _____
Macular degeneration	No	Yes _____
Retinal detachment	No	Yes _____
Crossed eyes	No	Yes _____
Blindness	No	Yes _____
Other:		_____

Please note any family history for the following conditions:

		(relation)
Arthritis	No	Yes _____
Diabetes	No	Yes _____
Cancer	No	Yes _____
Heart disease	No	Yes _____
High blood pressure	No	Yes _____
Lupus	No	Yes _____
Thyroid disease	No	Yes _____

The information below is kept strictly confidential; however, you may speak directly with the doctor if you prefer.

_____ Yes, I would prefer to speak directly with the doctor concerning the issues below.

Do you currently use or have you ever used any of the following:

Tobacco products	No	Yes
Alcohol	No	Yes
Illegal drugs	No	Yes
Other:		_____

Have you been exposed to or infected with any of the following:

Gonorrhea	No	Yes
Hepatitis	No	Yes
Syphilis	No	Yes
HIV	No	Yes

Doctor Signature: _____ **Date:** _____

For Office Use Only	Rev by _____ Date _____	Rev by _____ Date _____	Rev by _____ Date _____
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