

NAME: _____

DOB: _____

GENDER: male / female

PAST OCULAR INFORMATION

Date of last eye exam: _____

Do you wear glasses? No Yes

If yes, for reading only? No Yes Age of current glasses: _____

Are you having any eye symptoms? No Yes

If yes, please list: _____

Have you had any eye diseases? No Yes

If yes, please list: _____

Have you had eye surgeries? No Yes

If yes, please list: _____

Please check if your family has history of any of the following eye diseases:

None Cataract Glaucoma Macular Degeneration Other: _____

PAST MEDICAL HISTORY

Please check if you have had any of the following medical conditions:

None Asthma Diabetes High blood pressure Heart Disease

Other illness: _____

Please check if your family has history of any of the following medical conditions:

None Asthma Diabetes High Blood Pressure Heart Disease

Other illness: _____

List any medications (including eye drops) you are currently using: _____

List any previous surgeries: _____

List any DRUG ALLERGIES: _____

REVIEW OF SYSTEMS

Please circle Yes/No if you have any of the following problems:

Problems of the eye / vision:

- Y N General: Weight loss, Fever, Headache
Y N Ear/Nose/Throat: Hearing loss, Sinus Problems
Y N Heart: Chest pain, irregular heartbeat
Y N Respiratory: Short of breath, Wheezing, Asthma, Cough
Y N Digestive: Heartburn, Diarrhea, Reflux
Y N Neurologic: Paralysis, Numbness
Y N Skin: Rashes, Eczema
Y N Psychiatric: Depression, Anxiety, Mental illness
Y N Endocrine: Diabetes, Thyroid
Y N Cancer: Any type
Y N Blood: Anemia, Sickle Cell, Excessive bleeding
Y N Urinary: Kidney, Bladder

- Y N Burning
Y N Distorted vision
Y N Double vision
Y N Excess tearing/watering
Y N Eye pain or soreness
Y N Flashes/floaters in vision
Y N Fluctuating visual acuity
Y N Itching
Y N Loss of vision
Y N Loss of side vision
Y N Mucus discharge
Y N Redness
Y N Sandy or gritty feeling

Other: please list _____

SOCIAL HISTORY

Do you drink alcohol? No Yes

Do you smoke? No Yes

Do you have a history of drug abuse? No Yes

Do you drive? No Yes

Patient's signature: _____

Today's date: _____

Reviewer's signature: _____

Today's date: _____