Name: _____ Date: _____

Main Reason for Visit: _____

Circle all that apply

Do you wear: N/A

Glasses Soft Contact Lens Hard Contact Lens

Have you ever had: N/A

Spots/Floaters Flashes Eye Surgery Eye Injury

Eye Turn Eye Strain

Do you use computers for long hours? (>8 hr per day)

Yes No

Have you been told that you have: N/A

Lazy eye or Amblyopia Cataracts Glaucoma

Other Eye Disease

Does anyone in your family have: N/A

Glaucoma If yes, whom? _____

Other eye disease Specify: _____

Circle all that apply

Allergies: N/A

Hay fever Dust Fungus Animals Humidity

Foods Please specify allergies: _____

Cardiovascular problems: N/A

Hypertension Heart Disease Stroke

Other (specify):

Constitutional N/A

Blackouts Car sickness Cramps

Dizziness Disorientation Nausea Vomiting

Other (specify): _____

Endocrine problems: N/A

Diabetes Thyroid problems Renal Disorder

Other (specify): _____

Gastrointestinal problems: N/A

Heartburn Diarrhea Heptatitis

Other (specify):

Urinary Problems: N/A

Pain or discomfort Prostate Disorder Bladder Problem

Ovarian Disorder

Other (specify): _____

Ear / Nose / Throat Problems: N/A

Hearing Loss Sore Throat Sinusitis

Other (specify): _____

Blood Diseases: N/A

Anemia Hematologic disorder Lymphatic

Other (specify): _____

Immune problems: N/A

Immunodeficiency Tuberculosis

Other (specify): _____

Skin Problems: N/A

Acne Rashes Excessive dryness Dermatitis

Other (specify):

Musculoskeletal problems N/A

Muscle aches Joint Pain Swollen Joints Arthritis

Other (specify):

Neurological problems N/A

Brain Damage Dyslexia Epilepsy Seizures

Spinal Cord Injury

Other (specify):

Psychiatric problems: N/A

Depression Anxiety Insomnia Alzheimer Autism

Other (specify): _____

Respiratory Problems: N/A

Asthma Shortness of Breath Bronchitis Emphysema

Other (specify): _____

Other medical conditions not noted above: N/A

Cancer Pregnancy

Specify:

Have you ever had any surgery? **Yes** **No**

Please specify: _____

Does diabetes run in your family? **Yes** **No**

If yes, whom? _____

Does high blood pressure run in your family? **Yes** **No**

If yes, whom? _____

Do heart problems run in your family? **Yes** **No**

If yes, whom? _____

Do you smoke?

Yes No

If the patient is under <u>18 years old</u>, are immunizations up to date?

Yes No

List any prescription or over-the-counter eye drops you use:

_____ _____

_____ _____

_____ _____

List any prescription or over-the-counter medications you use:

_____ _____

_____ _____

_____ _____