

Patient Name _____ Today's Date _____

1) Please state your reason for today's visit:

2) EYE HISTORY * Do you currently wear eyeglasses? Y / N * Do you currently wear contact lenses? Y / N

* Please v check the box next to each condition to inform the doctor if have/had any of the eye conditions listed:

Eye or Vision Disorder NONE glaucoma macular degeneration cataract strabismus amblyopia
 other _____

Eye Surgery NONE specify type of surgery and date of surgery _____

Eye Injury NONE specify injuries _____

3) Smoking History Never Smoked Former Smoker Current Smoker _____

4) FAMILY HISTORY NONE Glaucoma Mom, Dad, Sibling? _____
 Macular Degeneration Mom, Dad, Sibling? _____
 Other _____

5) REVIEW OF SYSTEMS/HEALTH

* Please v check the box next to each organ system to inform the doctor if you have/had any of the conditions listed:

Ear, Nose, Throat NONE Hearing Loss Chronic Sinusitis Dry Mouth Other _____

Neuro NONE Multiple Sclerosis (MS) Migraine Concussion Parkinson's Dis Alzheimer's Dis
 Epilepsy Cerebral Palsy (CP) Stroke other _____

Psych NONE Anxiety Depression Bipolar Post-Traumatic Stress other _____

Cardiovascular: NONE High Blood Pressure High Cholesterol Heart Disease other _____

Respiratory NONE COPD Asthma Sleep Apnea other _____

Gastro-Intestinal NONE Acid Reflux Crohn's Colitis other _____

Musculo-Skeletal NONE Arthritis Connective tissue disease other _____

Skin NONE Eczema Psoriasis Basal Cell Carcinoma other _____

Endocrine NONE Diabetes (Type 1) Diabetes (Type 2) Thyroid Dysfunction other _____

Blood & Lymph NONE Anemia Leukemia other _____

Allergy & Immune NONE Environmental Allergies Rheumatoid Arthritis Lupus _____

Cancer NONE Lymphoma Breast Cancer Prostate Cancer other _____

Other NONE Autism behavioral disorder learning disability other _____

6) MEDICATIONS NONE Please list ANY medications that you use regularly (include pills, injections, eye drops):

7) Do you have any allergies to medications? Yes / No Please list: _____

I acknowledge the above information is complete, true, and correct _____

Patient or Guardian SIGNATURE