Name____ Birthdate________________

Date of last eye exam? ______________ Name of last eye physician?_____________________

Current Medications (including non-prescription) ____

____

____

Are you allergic to any medications? ☐ No ☐ Yes If yes, please list:____________________________

<u>Past Medical History</u>: (Problems)

☐ Thyroid Disease ☐ High Blood Pressure ☐ HIV ☐ Diabetes: ☐ Insulin ☐ Non-Insulin
☐ Heart Disease ☐ Hepatitis Type_____ ☐ TB Last Blood Sugar______ Last A1C_____
☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts

☐ Other_____________________________________

☐ Eye Injuries please list____

<u>Patient Social History</u>: (PFSH)

Do you smoke?: Y or N, If so how often___________ Have you used tobacco in the last 30 days? Y or N
Have you used smokeless tobacco in the last 30 days? Y or N
Do you use illegal drugs? Y or N, If so what kind? ____
Do you drink Alcohol? Y or N, If so circle one: Social Moderate Excessive

<u>Family History</u>: If yes, note the relationship to the patient.

☐ Glaucoma______________________________ ☐ Macular Degeneration___________________________
☐ Diabetes_______________________________ ☐ Other ____

<u>Review of Systems</u>:(ROS) Do you have any of the following? (Please circle any that apply)

<u>Constitutional:</u> weight gain or loss, fever or chills, insomnia, fatigue, weakness

<u>Ears/Nose/Throat/Mouth:</u> cough, stuffy nose, hay fever, nosebleeds, sinus congestion, dry mouth

<u>Cardiovascular:</u> arrhythmia, chest pain, history of heart disease, high cholesterol, murmur, pacemaker, difficulty breathing

<u>Respiratory:</u> asthma, bronchitis, emphysema, COPD, hemoptysis, lung cancer, pneumonia, tuberculosis

<u>Gastrointestinal:</u> diarrhea, constipation, loss of appetite, abdomen pain, nausea/vomiting, heartburn

<u>Genitourinary:</u> problems with genitals, kidneys, bladder, or urination, dialysis, hematuria, incontinence

<u>Musculoskeletal:</u> rheumatoid arthritis, muscle pain, joint pain, stiffness, back pain, redness of joints

<u>Integumentary:</u> eczema, rashes, lumps, itching, dryness, color changes, hair and nail changes, psoriasis

<u>Neurologic:</u> dizzness/vertigo, epilepsy, fainting, seizures, weakness, migraines, numbness, paralysis

<u>Psychiatric:</u> agitated, memory loss, confused, depression, dementia, mood swings, nervousness

<u>Endocrine:</u> heat or cold intolerance, sweating , frequent urination, frequent thirst, change in appetite

<u>Blood/Lymphatic:</u> anemia, bleeding problems, ease of bruising, leukemia

<u>Allergic/Immunologic:</u> rheumatoid arthritis, lupus

Have you had any of the following eye surgeries?
☐ Cataract ☐ Yag Laser ☐ ICL ☐ RK ☐ Lasik ☐ PRK If yes year done?________ Which eye? ______
By Dr.______________________________________

<u>Social Occupational History</u>: List any special vision needs:__________________________________

Are you pregnant or nursing? ☐ No ☐ Yes If yes, please give due/delivery date:__________________

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

____ ____________
Patient, Parent or Legal Guardian's Signature If patient is under 18 years of age) Date