In order to better treat you, please provide the following medical history.

Patient Name:_____ **Date of Birth:**_____

Who is your Primary Care Physician?_____

Ocular History:

Have you ever been diagnosed with:

	Yes	No	
Dry Eyes	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Diabetic Retinopathy	☐	☐	
Retinal Detachment	☐	☐	
"Lazy Eye"	☐	☐	left or right?

Please list any eye drops or oral eye vitamins you are taking:

_____

_____

_____

_____

_____

_____

_____

_____

Have you ever had any eye surgery or eye trauma? ***Please describe:***_____

_____

_____

Systemic History:

Do you have, or have you previously had, a medical history of:

	Yes	No	
High Blood Pressure	☐	☐	
Diabetes	☐	☐	
year diagnosed?_____			
Heart Disease	☐	☐	
Stroke	☐	☐	
what year?_____			
Heart Attack	☐	☐	
what year?_____			
Cancer	☐	☐	
what kind?_____			

Please list any prescription or over--the-counter medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you allergic to any medications or drugs? ☐ Yes ☐ No known drug allergies

If yes, please list and describe effect:_____

_____

Family History:

Do you have a family history of:

	Yes	No
Retinal Disease	☐	☐
Glaucoma	☐	☐
Diabetes	☐	☐

	Yes	No
Have you fallen within the last year?	☐	☐

If so, how many times?_____

Were you injured or hospitalized? _____

Have you had a flu vaccine?		
If yes, when?_____	☐	☐
Have you had a pneumonia vaccine?		
If yes, when?_____	☐	☐

Social History:

Tobacco use? Yes / No / Former

If yes, how much per day?_____

Alcohol use? Yes / No / Former

If yes, daily or social?_____

Caffeine use? Yes / No / Former

If yes, how much per day?_____

Drug use? Yes / No / Former

Continued on back

Review of Systems

Please **CHECK** Yes or No, then **CIRCLE or ADD** any symptoms that apply to you **TODAY**.
Please provide this to your technician who calls you back along with your list of current medications.

Who is your Primary Care Physician? _____

	Yes	No	
Constitutional Symptoms	O	O	_____

Example: fatigue, fever, night sweats, weakness, weight gain, weight loss

Ears, Nose, Mouth & Throat	O	O	_____

Example: hearing loss, hoarseness, lump in neck, nasal congestion, sinus problems, sore throat, tinnitus, vertigo

Respiratory	O	O	_____

Example: asthma, cough, labored breathing, labored breathing on exertion, spitting up blood, wheezing

Cardiovascular	O	O	_____ _____

Example: arrhythmia, calf pain, chest discomfort, irregular heartbeat/palpitations, leg swelling, tachycardia

Gastrointestinal	O	O	_____

Example: abdominal pain, black tarry stools, constipation, decreased appetite, diarrhea, difficulty swallowing, food intolerance, heartburn, increased appetite, jaundice, nausea, vomiting

Genitourinary	O	O	_____

Example: pain with urination, genital lesions, blood in urine, irregular period, urethral discharge, urinary urgency

Metabolic/Endocrine	O	O	_____ _____

Example: cold intolerance, heat intolerance, excessive thirst, excessive hunger, large volume of urine

Neurological	O	O	_____

Example: balance disturbances, dizziness, focal weakness, gait disturbance, headaches, memory difficulty, numbness

Psychiatric	O	O	_____

Example: depressed mood, frequent nightmares, hallucinations, insomnia, irritability, nervousness, stress

Integumentary	O	O	_____

Example: abnormal hair distribution, dry skin, hives, itching skin, nail changes, rash, skin changes, skin lesion, skin nodules, skin sores, ulcers

Musculoskeletal	O	O	_____

Example: arthritis, back pain, fracture, joint stiffness/swelling, muscle cramping/ weakness

Hematologic/Lymphatic	O	O	_____

Example: bleeding, bruising, disease of the lymph nodes, tender lymph nodes

Immunologic	O	O	_____

Example: environmental allergies, food allergies, seasonal allergies