

D.O.B.	Name:	Date:	ACCT:
--------	-------	-------	-------

Occupation?	Hobbies?	Special Needs:
-------------	----------	----------------

Do You Wear <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Readers <input type="checkbox"/> Nothing (none)	<input type="checkbox"/> Full Time Wearer <input type="checkbox"/> Part Time Wearer
---	---

List Any Eye Surgery You Have Had	Which eye?	When/Year?	Dr. Name?
-----------------------------------	------------	------------	-----------

My Vision (with glasses or contacts) is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Your Preferred Pharmacy ?	City?
--	---------------------------	-------

What is the main reason for your visit today?
Explain

Do You Have Any Vision Problems? Complaints? Concerns?		Tobacco Use	High Risk
Y N Blurry Vision <input type="checkbox"/> Near <input type="checkbox"/> Far	Y N <input type="checkbox"/> Itchy <input type="checkbox"/> Red <input type="checkbox"/> Dry <input type="checkbox"/> Allergies	Y N Current Smoker	Y N Do you take Plaquenil? (hydroxychloroquin)
Y N <input type="checkbox"/> Fuzzy <input type="checkbox"/> Filmy <input type="checkbox"/> Hazy Vision	<input type="checkbox"/> Scratchy Sensation <input type="checkbox"/> Water	<input type="checkbox"/> Every day	
Y N <input type="checkbox"/> Glare <input type="checkbox"/> Halos	<input type="checkbox"/> Tearing <input type="checkbox"/> Discharge <input type="checkbox"/> Crusty	<input type="checkbox"/> Some days	Y N Do you take Topamax? (Topiramate)
Y N Gradual Vision Changes	Y N Headaches	Y N Former Smoker	Y N Are You Pregnant? Or Nursing ?
Y N Sudden Onset Vision Loss	Y N Flashes of Light	Y N Chewing Tobacco	NA
Y N Reduced Vision @ Night Driving/Rain	Y N Floaters	Y N Never a smoker	(IMPORTANT: Tell us before we insert any eye drops)
Y N Fluctuating Vision	Y N Cataracts Worsening		
Y N Other _____	Y N Other _____		

REVIEW OF SYSTEMS (Self) Please circle or write in any current or chronic illnesses, symptom or problems.

Constitution	Neurological	Stomach / Intestines	Blood / Circulation
Y N Fever	Y N Seizures/Epilepsy	Y N Abdominal Pain	Y N Bleed/bruise easy
Y N Night Sweats	Y N Bell's Palsy	Y N Other _____	Y N HIV/AIDS
Y N Other _____	Y N Alzheimer's Disease	Urinary / Reproductive	Y N Other _____
Cardiovascular	Y N Migraines	Y N Kidney Trouble	Endocrine / Hormonal
Y N Heart Disease	Y N Vertigo	Y N Renal Disease	Y N Thyroid Disorder
Y N Elevated Cholesterol	Y N Stroke:Date _____	Y N Other _____	Y N Diabetes
Y N Other _____	Y N Other _____	Bones / Joints / Muscle	Y N Other _____
Ears, Nose, Mouth, Throat	Skin / Hair / Nails	Y N Sjogren's Syndrome	Respiratory / Lungs
Y N Hearing Aid	Y N Rosacea	Y N Rheumatoid Arthritis	Y N Chronic Cough
Y N Sinus Pain	Y N Melanoma	Y N Fibromyalgia	Y N COPD
Y N Ringing Ears	Y N Basal Cell Carcinoma	Y N Multiple Sclerosis	Y N Asthma
Y N Other _____	Y N Other _____	Y N Other _____	Y N Other _____

(SKIP this section If you're not diabetic)

Diabetic Info :	Diabetic Controlling Factors:	A1C: Level: _____ Date: _____	Yr Diagnosed _____ *Who Is Your Diabetic Dr?
Y N Type I	Y N Oral Medications	Blood Sugar Level: _____ Date: _____	Name? _____ Practice? _____ Location? _____
Y N Type II	Y N Insulin		
Y N Controlled	Y N Dietary Discipline		
Y N Uncontrolled			

FAMILY History: Please List Family Member Relation Next to Medical Condition Below Adopted Unknown

(not self) List Immediate 1 st generation FAMILY Relationship Below (Mom, Dad, Bro. Sis. Son, Daughter)		<input type="checkbox"/> No significant family history	
Y N Cataract:	Y N Blindness:	Y N Glaucoma:	Y N Macular Degen:
Y N Diabetes:	Y N RetinaDisease	Y N Eye Disease	Y N Other :

List Eye Drops (include over the counter & Rx)	Dose	List All Medications, or Supply a Copy	Dose
1		1	
2		2	
3		3	
4		4	
List Any Known Drug Allergies		5	
1		6	
2		7	
3		8	

Patient Signature X _____ Date: _____