D.O.B.	Name:	Date:	ACCT:
Occupation?	Hobbies?	Special Needs:	

Do You Wear □Glasses □ Contacts □ Readers □Nothing (none) □ Full Time Wearer □ Part Time Wearer

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

My Vision (with glasses or contacts) is: □ Good □ Fair □ 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 □Near □ Far	Y N	□ Itchy □Red □ Dry □Allergies	Y N	Current Smoker □Every day □Some days	Y N	Do you take Plaquenil? (hydroxychloroquin)
Y N	□ Fuzzy □ Filmy □Hazy Vision		□ Scratchy Sensation □Water				
Y N	□ Glare □Halos		□Tearing □Discharge □Crusty	Y N	Former Smoker	Y N	Do you take Topamax? (Topiramate)
Y N	Gradual Vision Changes	Y N	Headaches				
Y N	Sudden Onset Vision Loss	Y N	Flashes of Light	Y N	Chewing Tobacco	Y N	Are You Pregnant?
Y N	Reduced Vision @ Night Driving/Rain	Y N	Floaters			NA	Or Nursing ?
Y N	Fluctuating Vision	Y N	Cataracts Worsening	Y N	Never a smoker		(IMPORTANT: Tell us before we insert any eye drops)
Y N	Other_____		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:			
Y N	Type I	Y N	Oral Medications	**A1C:**	Level: _____	**Yr Diagnosed** _____
Y N	Type II	Y N	Insulin		Date:_____	***Who Is Your Diabetic Dr?**
Y N	Controlled	Y N	Dietary Discipline			*Name?*_____
Y N	Uncontrolled			**Blood Sugar**	Level: _____	*Practice?* _____
					Date: _____	*Location?*_____

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

{not self} List Immediate 1st generation FAMILY Relationship Below (Mom, Dad, Bro. Sis. Son, Daughter) □ 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
1		
2		
3		
4		
	List Any Known Drug Allergies	
1		
2		
3		

	List All Medications, or Supply a Copy	Dose
1		
2		
3		
4		
5		
6		
7		
8		

Patient Signature X _____ Date: _____