

D.O.B.	Name:	Date:	ACCT:
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Occupation?	Hobbies?	Special Needs:
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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
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List Any Eye Surgery You Have Had	Which eye?	When/Year?	Dr. Name?
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My Vision (with glasses or contacts) is: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Your Preferred Pharmacy ?	City?
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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 Do you take Topamax? (Topiramate)
Y N <input type="checkbox"/> Glare <input type="checkbox"/> Halos	<input type="checkbox"/> Tearing <input type="checkbox"/> Discharge <input type="checkbox"/> Crusty	Y N Former Smoker	Y N Are You Pregnant? Or Nursing ?
Y N Gradual Vision Changes	Y N Headaches	Y N Chewing Tobacco	
Y N Sudden Onset Vision Loss	Y N Flashes of Light / Floaters		
Y N Reduced Vision @ Night Driving/Rain	Y N Other_____		
Y N Fluctuating Vision			

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

Constitution	Respiratory / Lungs	Bones / Joints / Muscle	Psychiatric
Y N Developmental Disability	Y N Chronic Cough	Y N Fibromyalgia	Y N Other_____
Y N Trauma	Y N COPD	Y N Osteoarthritis	Endocrine / Hormonal
Y N Fever	Y N Asthma	Y N Muscular Dystrophy	Y N Thyroid Disorder
Y N Other_____	Y N Other_____	Y N Other_____	Y N Diabetes
Cardiovascular	Stomach / Intestines	Skin / Hair / Nails	Y N Other_____
Y N Heart Disease	Y N Abdominal Pain	Y N Rosacea	Blood / Circulation
Y N High Blood Pressure	Y N Crohn's / Colitis	Y N Eczema	Y N Anemia
Y N Elevated Cholesterol	Y N Digestive Disorder	Y N Skin Cancer	Y N Leukemia
Y N Stroke: Date_____	Y N Other_____	Y N Other_____	Y N HIV/AIDS
Y N Other_____	Urinary / Reproductive	Neurological	Y N Other_____
Ears, Nose, Mouth, Throat	Y N Kidney Trouble	Y N Multiple Sclerosis	Allergic/Immunologic
Y N Hearing Disorder	Y N Trouble Urinating	Y N Seizures/Epilepsy	Y N Environmental Allergy
Y N Sinus Pain	Y N Other_____	Y N Bell's Palsy	Y N Autoimmune Disease
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 _____
Y N Type I	Y N Oral Medications	Blood Sugar Level: _____ Date: _____	*Who Is Your Diabetic Dr?
Y N Type II	Y N Insulin		Name? _____
Y N Controlled	Y N Dietary Discipline		Practice? _____
Y N Uncontrolled			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	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: _____