Name: _____ Date: _____

DOB:_____ Acct #:_____

Medical/ Ocular History

Past Ocular History:

	Yes	No		Yes	No
Cataracts	☐	☐	Amblyopia/ Lazy eye	☐	☐
Glaucoma	☐	☐	Surgery/Other: _____		
Macular Degeneration	☐	☐	_____		
Retinal/detachment	☐	☐	_____		

Past Medical/ Surgical History

	Yes	No		Yes	No
High blood pressure	☐	☐	Cancer (type:_____)	☐	☐
Diabetes: Type 1/ Type 2	☐	☐	Heart disease	☐	☐
High cholesterol	☐	☐	Surgery/ Other: _____		
Thyroid (hypo/ hyper)	☐	☐	_____		
			_____		

Medication with strength: (Including vitamins): *Attach list if applicable*

_____ _____

_____ _____

_____ _____

Preferred Pharmacy: _____ Phone #: _____

Mail Order Pharmacy: _____ Phone #: _____

Medication or Drug Allergies:_____

Family Ocular/ Medical History: Indicate family member

Cataract _____ Diabetes _____

Hypertension_____ Glaucoma _____

Macular Degeneration_____ Amblyopia/ lazy eye _____

Retinal detachment _____ Blindness _____

Social History:

Alcohol Use: Yes ☐ No ☐ **Tobacco Use**: None ☐ Circle: Current/Former/Never

Women: Pregnant ☐ Nursing ☐ Frequency/ Amount: _____

Name: _____ Date: _____

DOB:_____ Acct #:_____

Review of Systems: Do you have these now? If so circle condition and explain.

Yes	No	
☐	☐	**Allergy:** Seasonal/ Year round: _____
		_____
☐	☐	**Cardiovascular:** High/ Low blood pressure/ chest pain/ irregular beat
		_____
☐	☐	**Constitutional:** Fever/ weight gain or loss/ fatigue _____
		_____
☐	☐	**Endocrine:** High sugar/ High thyroid/ low thyroid _____
		_____
☐	☐	**ENT:** Hearing loss/ sinus _____
		_____
☐	☐	**Eye:** Blurred vision/ eye pain/ flashes/ floaters _____
		_____
☐	☐	**GI:** Abdominal Pain/ nausea/ vomiting/ diarrhea _____
		_____
☐	☐	**GU:** FLOMAX use/ groin pain/ sores _____
		_____
☐	☐	**Blood:** Anemia/ easy bruising/ swollen lymph nodes _____
		_____
☐	☐	**Skin:** Rashes/ changing moles/ eczema _____
		_____
☐	☐	**Musculoskeletal:** Joint pain/ weakness/ back pain _____
		_____
☐	☐	**Neurological:** Headache/ scalp tenderness/ jaw pain _____
		_____
☐	☐	**Psychiatric:** Anxiety/ depression _____
		_____
☐	☐	**Respiratory:** Shortness of breath/ Sleep apnea/ CPAP _____