Eye History

Have you had any eye surgeries or eye injuries? (Please circle) **Yes** **No**
If yes, please list:_____
Check any problems you are currently having:

- ☐ Blurred Vision
- ☐ Flashing Lights
- ☐ Floaters
- ☐ Other_____
- ☐ Double Vision
- ☐ Watering, Itching, Burning
- ☐ Glare
- ☐ Red Eye(s)
- ☐ Eye Pain
- ☐ Dry Eye

Family & Social History

***Has anyone in your family ever had**:*

Macular Degeneration	Y	N	High Blood Pressure	Y	N
Retinal Degeneration	Y	N	Diabetes	Y	N
Glaucoma	Y	N	Heart Disease	Y	N
Cataracts	Y	N			
Other Eye Conditions	Y	N	Please explain: _____		
Do you live alone?	Y	N	Have you ever used tobacco?	Y	N
*What is your occupation?*_____			Do you use tobacco?	Y	N *How much?*_____
*Date of last tetanus shot?*_____			Do you use alcohol?	Y	N *How much?*_____
Special needs? Hearing impaired, wheelchair, translator			Other substances?	Y	N *How much?*_____

Past Medical History

Have you ever been diagnosed with:

High Blood Pressure	Y	N	HIV/AIDS	Y	N	Emphysema	Y	N
Heart Disease	Y	N	Kidney Disease	Y	N	Diabetes	Y	N
Pace Maker	Y	N	Stroke	Y	N	Osteoporosis	Y	N
Defibrillator	Y	N	Cancer	Y	N	Arthritis	Y	N
Thyroid Disease	Y	N	Anemia	Y	N	Depression	Y	N
Lung Disease	Y	N	Asthma	Y	N	Tuberculosis	Y	N
Surgeries	Y	N …List: _____						

Medications

Please list ALL medications or eye drops you are using, including: vitamins, aspirin, birth control pills, etc. ☐ Check box if medication list is attached

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Allergies

Are you allergic to any drugs or over the counter medications? Y N Please list below: Are you allergic to latex? Y N

1.	3.	5.
2.	4.	6.

Medical Review (Check any problems that apply to you)

Constitutional:
- ☐ Weight Gain/Loss
- ☐ Chronic Fatigue
- ☐ Fever/Chills

Neurological:
- ☐ Numbness/Weakness
- ☐ Loss of Memory
- ☐ Dizziness
- ☐ Slurred Speech
- ☐ Headache

Urinary Tract:
- ☐ Painful Urination
- ☐ Incontinence
- ☐ Difficult Urination

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal Pain

Endocrine:
- ☐ Hormone Therapy
- ☐ Excessive Thirst
- ☐ Frequent Urination

Respiratory:
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Coughing
- ☐ Asthma
- ☐ Lung Disease
- ☐ Dyspnea on Exertion

Allergy/Immunity:
- ☐ Environmental Allergies
- ☐ Hay Fever

Heart/ Circulation:
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Sleep with Extra Pillows
- ☐ Extremity Swelling

Hematological:
- ☐ Easy Bruising
- ☐ Low Blood Count

Integumentary:
- ☐ Rashes
- ☐ Lumps in Breast

Musculoskeletal:
- ☐ Painful Joint
- ☐ Swollen Joints

Ears/Nose/Throat:
- ☐ Loss of Hearing
- ☐ Sinus Problems
- ☐ Swollen Glands
- ☐ Nosebleeds

UPDATED:
