For Your Eyes Site

Patient Name_____**D.O.B**._____**Date**:_____

Address, City, Zip:_____

Phone Number:_____ Email:_____

Please Complete Entire Form
Primary Doctor and Contact Information:

_____
_____

General Health

Headaches Y N Duration_____
Seasonal Allergies Y N
Diabetes Y N
Thyroid Y N
Dry mouth/sores Y N
Sinus Problems Y N
fatigue Y N
HIV/AIDS/STD Y N

High Blood Pressure Y N
High Cholesterol Y N
Heart/bypass/attack Y N
Cancer (type)_____
Hepatitis Y N
Weight Change, fever,

For the following questions, if *"yes," please explain*
Shortness of Breath, chronic cough, asthma Y N_____
Gastrointestinal (intestine, stomach) Y N_____
Musculoskeletal (joints, muscles, arthritis) Y N_____
Neurological (numbness, paralysis, weakness) Y N_____
Psychiatric (anxiety, depression) Y N_____

Past Medical History
Please list major illnesses/injuries

Social HistoryDrug Allergies
Current Occupation**: _____**
Do you drive? Y N_____
Do you drink alcohol? Y N_____
If yes, amount & frequency**_____**

Do you smoke? Y N_____
If yes, amount & frequency**_____**

Current Medications (please include eye drops)

_____
_____

Past Eye History

Glasses/Contacts Y N
Lazy Eye Y N
Corneal Problems Y N
Corneal Problems Y N
Cataract(s)Y N
Retinal Detachment Y N
Macular Degeneration Y N
Diabetic Retinopathy Y N
Other Eye Injuries/Surgery Y N
Other Problems_____

Family Eye History

For the following questions, if answer is "yes" please indicate if Parent, Sibling or Child

Blindness Y N Parent Sibling Child
Cataract Y N Parent Sibling Child
Glaucoma Y N Parent Sibling Child
Macular Degeneration Y N Parent Sibling Child
Diabetic Retinopathy Y N Parent Sibling Child
Lazy Eye Y N Parent Sibling Child
Other Y N Parent/Sibling/Child If yes, please explain

_____
_____

Eye Symptoms You Are Experiencing Today (please check all that apply)

Blurred, distorted, loss of vision Y N
Buring, dryness, itching Y N
Chronic infection of eye or lid Y N
Crossed eyes or lazy eye Y N
Discharge or excessive tearing Y N
Double VisionY NRednessY N
Other: if yes, please list below Y N
Stye or chalazion/eyelid bumpY N
Drooping eyelid Y N
Flashes of light or floaters (black spots) Y N
Foreign body sensation (sand or gritty) Y N
Glare or light sensitivity Y N
Pain or soreness (1 to 10)_____Y N

_____
_____

Date_____
If completed questionnaire before, has anything changed since your last visit: Please review General Health, Past Medical History & Social History.
If yes, please explain: _____
Drug AllergiesY N please list:_____

Any new eye symptoms today:

_____