

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Email: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Last Eye Exam (date): \_\_\_\_\_  
 Last Medical Exam (date): \_\_\_\_\_ Last Medical Doctor (name): \_\_\_\_\_

<b>Patient Ocular/Medical History</b>	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/Blindness		
Eye Turn/Strabismus		
Lazy Eye/Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Disease(s)/Prematurity		
Do you wear glasses?		
Do you wear contact lenses?		
<i>If NO, would you like to?</i>		
Have you ever had a <b>surgery</b> on your eyes?		

*If YES, what was it? Why did you have it performed?*

<b>Family Ocular/Medical History</b>	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Loss of Vision/Blindness		
Eye Turn/Strabismus		
Lazy Eye/Amblyopia		
Eye Infection		
Dry Eye		
High Blood Pressure/Hypertension		
Diabetes		
Other Disease(s)/Prematurity		

What is your preferred pharmacy? \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Do you have any allergies to medications? \_\_\_\_\_  
 Do you have environmental allergies? \_\_\_\_\_

<b>Social History</b>	Yes	No
Do you smoke?		
<i>If YES, do you smoke every day?</i>		
<i>If NO, did you used to smoke?</i>		
Do you use recreational drugs		
Do you drink alcohol?		
Are you currently pregnant or nursing?		
What is your occupation?		
What are your hobbies?		
How many hours a day do you use a computer?		
What is your current height?		
What is your current weight?		

<b>Patient Review of Health</b>	Yes	No
<i>Do you currently have or ever had problems in the following areas?</i>		
<b>Constitution</b> (Fever, Weight Gain/Loss)		
<b>Cardiovascular/Vascular</b> (Diabetes, High Blood Pressure, Stroke)		
<b>Ears, Nose, Throat, Mouth</b> (Allergies, Sinus Congestion, Dryness)		
<b>Respiratory</b> (Asthma, Bronchitis, Emphysema)		
<b>Gastrointestinal</b> (Diarrhea, Constipation)		
<b>Genitourinary</b> (Genitals, Kidney, Bladder Problems)		
<b>Musculoskeletal</b> (Arthritis, Joint/Muscle Pain)		
<b>Integumentary</b> (Skin Problems)		
<b>Neurological</b> (Headaches, Migraines, Seizures)		
<b>Psychiatric</b> (Mental/Emotional Problems)		
<b>Endocrine</b> (Thyroid/Other Gland Problem)		
<b>Hematologic/Lymphatic</b> (Anemia, Bleeding Problems)		
<b>Allergic/Immunologic</b> (Allergy)		

**Medications**  
*List all medications that you currently take (including over-the-counter, vitamins, supplements, oral contraceptives, etc.)*

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