

**Visual History:** Please indicate all that apply

Blurry far   Blurry near   Tearing   Itchy   Dryness   Pain   Discomfort   Headaches   Glare   Contact Lens Discomfort

Are you sensitive to (circle all that apply) Heaters   Blowers   Air Conditioning   Cigarettes   Smog   Dust   Pollen   Contacts   Animals   Contact Lens Solution

Do you currently wear glasses/contact lenses?  Yes    No   Name of last eye doctor and exam date \_\_\_\_\_

**Medical History:**

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

Do you have DIABETES?    YES    NO   How many years? \_\_\_\_\_   Using Medication?    YES    NO  
Do you have HYPERTENSION?    YES    NO   How many years? \_\_\_\_\_   Using Medication?    YES    NO  
Do you have Cholesterol Problems?    YES    NO   How many years? \_\_\_\_\_   Using Medication?    YES    NO  
Females: Are you Pregnant/Nursing?    YES    NO

**Medications:** (Please list any and all medications including Over the Counter, Homeopathic, Birth Control or Remedies): \_\_\_\_\_

Are you ALLERGIC to any Medications?    YES    NO   I am allergic to: \_\_\_\_\_

List and date all Major Injuries, Surgeries (LASIK?), and Hospitalizations you have had: \_\_\_\_\_

**Review Of Systems (ROS):** Do you have Current or Past problems with:

**Ocular ROS:**

**Indicate which eye(s)**

Constitutional:	Fever, Weight Loss, Appetite	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sudden Vision Loss	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Integumentary:	Skin conditions/disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO	Blurred Vision	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Neurological:	Headaches, Migraine, Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO	Loss of Side Vision	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Endocrine:	Thyroid, Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Double Vision	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Ears, Nose Throat:	Allergies, Sinus, Cough, Dry Throat/Mouth	<input type="checkbox"/> YES <input type="checkbox"/> NO	Floaters	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Respiratory:	Asthma, Emphysema, Bronchitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Flashes of Light	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Vascular:	Hypertension, Stroke, Heart Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mucus Discharge	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Gastrointestinal:	Diarrhea, Constipation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Redness	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Genitourinary:	Genitals, Kidneys, Bladder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Gritty Feeling/Dryness	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Bones/ Joints:	Rheumatoid Arthritis, Muscle Pain	<input type="checkbox"/> YES <input type="checkbox"/> NO	Itching/ Burning	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Lymphatic/Hematologic:	Anemia, Bleeding	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tearing/Watery	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Allergic Immunologic:	Allergies, Immune	<input type="checkbox"/> YES <input type="checkbox"/> NO	Glare/Light Sensitivity	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
Psychiatric:	Depression, Anxiety	<input type="checkbox"/> YES <input type="checkbox"/> NO	Eye Pain/ Discomfort	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L
			Haloes at Night	<input type="checkbox"/> YES <input type="checkbox"/> NO	R   L

**Family History:**

	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Relationship to you (parents, grandparents, siblings):
Blindness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Cataracts	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Glaucoma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Macular Degeneration	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Retinal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Heart Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Kidney Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
Thyroid Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

Any Other? Explain: \_\_\_\_\_

**Social:** (this information is strictly confidential, you may discuss this part with the doctor)    Check here to discuss with Doctor

Do you drive?    YES    NO   Do you have visual difficulty driving?    YES    NO   Explain \_\_\_\_\_

Use of tobacco products?    YES    NO

Use of alcohol products?    YES    NO

Use of illicit drugs?    YES    NO

Have you been exposed to any Infectious Disease (HIV, STD's, Hepatitis, TB)    YES    NO   Explain \_\_\_\_\_

**Whom can we thank for your referral?**

Friend/Co-worker \_\_\_\_\_ Insurance Company \_\_\_\_\_ Walk-In \_\_\_\_\_

Medical professional \_\_\_\_\_ Website \_\_\_\_\_ Other \_\_\_\_\_